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**MEMBER INFORMATION**

**Eligibility Verification**

All participating providers are responsible for verifying a member’s eligibility at each and every visit. Please note that membership data is subject to change. The Center for Medicare and Medicaid Service (CMS) retroactively terminates members for various reasons. When this occurs, the Cigna-HealthSpring claim recovery unit will request a refund from the provider. The provider must then contact CMS Eligibility to determine the member’s actual benefit coverage for the date of service in question.

You can verify member eligibility the following ways:

- Call the Health Plan – You must call the Health Plan to verify eligibility when the member cannot present identification or does not appear on your monthly eligibility list. Please note, the Health Plan should have the most updated information, therefore, call the Health Plan for accuracy.

- HSConnect – The Cigna-HealthSpring web portal, HSConnect, allows our providers to verify member eligibility online through visiting [https://HealthSpring.hsconnectonline.com/HSConnect](https://HealthSpring.hsconnectonline.com/HSConnect)

- Through our Interactive Voice Response (IVR) System at 1-800-230-6138. The IVR System is available 24 hours a day, 7 days a week.

- Ask to see the Member’s Identification Card – Each member is provided with an individual membership identification card. Noted on the ID card is the Member’s identification number, plan code, name of PCP, co-payment, and effective date. Since changes do occur with eligibility, the card alone does not guarantee the member is eligible.

- Pursue additional proof of identification – Each PCP and specialist office is provided with a monthly Eligibility report upon request which lists new and current Cigna-HealthSpring members with their effective dates. Please be sure to refer to the most current month’s eligibility listing.

### 2014 ID Cards

#### 2014 MA ID CARD

*Cigna HealthSpring*

Health Plan (80840)
Member ID: <Member ID>
Name: <Member Name>
PCP: <PCP>
PCP Phone: <PCP Phone Number>
Network: <PCP Network>
Copays: <Copay Amounts>

*This card does not guarantee coverage or payment.*

*Services may require a referral by the PCP or authorization by the health plan.*

**Members**

Customer Service: <number>
TTY: <TTY number>
24-Hour Health Information Line: <Phone Number>

**Medical Providers**

Provider Services: <number>
Authorization/Referral: <number>
Claims: <claims address>

Website: <URL>

#### 2014 MAPD ID CARD

*Cigna HealthSpring*

Health Plan (80840)
Member ID: <Member ID>
Name: <Member Name>
PCP: <PCP>
PCP Phone: <PCP Phone Number>
Network: <PCP Network>
Copays: <Copay Amounts>

*This card does not guarantee coverage or payment.*

*Services may require a referral by the PCP or authorization by the health plan.*

**Members**

Customer Service: <number>
TTY: <TTY number>
24-Hour Health Information Line: <Phone Number>

**Medical Providers**

Provider Services: <number>
Authorization/Referral: <number>
Claims: <claims address>

Website: <URL>
Maximum Out-of-Pocket (MOOP)

The Maximum Out-of-Pocket (MOOP) benefit is now a part of all Cigna-HealthSpring Benefit Plans. Members have a limit on the amount they will be required to pay out-of-pocket each year for medical services which are covered under Medicare Part A and Part B. Once this maximum out-of-pocket expense has been reached, the member no longer is responsible for any out-of-pocket expenses, including any cost shares, for the remainder of the year for covered Part A and Part B services (excluding the members’ Medicare Part B premium and Cigna-HealthSpring plan premium).

Member Hold Harmless

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

Member Confidentiality

At Cigna-HealthSpring, we know our members’ privacy is extremely important to them, and we respect their right to privacy when it comes to their personal information and health care. We are committed to protecting our members’ personal information. Cigna-HealthSpring does not disclose member information to anyone without obtaining consent from an authorized person(s), unless we are permitted to do so by law. Because you are a valued provider to Cigna-HealthSpring, we want you to know the steps we have taken to protect the privacy of our members. This includes how we gather and use their personal information. Cigna-HealthSpring’s privacy practices apply to all of Cigna-HealthSpring’s past, present, and future members.

When a member joins a Cigna-HealthSpring Medicare Advantage plan, the member agrees to give Cigna-HealthSpring access to Protected Health Information. Protected Health Information (“PHI”), as defined by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), is information created or received by a health care provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present, or future physical or behavioral health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any form or medium. Access to PHI allows Cigna-HealthSpring to work with providers, like yourself, to decide whether a service is a Covered Service and pay your clean claims for Covered Services using the members’ medical records. Medical records and claims are generally used to review treatment and to do quality assurance activities. It also allows Cigna-HealthSpring to look at how care is delivered and carry out programs to improve the quality of care Cigna-HealthSpring’s members receive. This information also helps Cigna-HealthSpring manage the treatment of diseases to improve our members’ quality of life.

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

• Send Cigna-HealthSpring a written request to see or get a copy of information about them, or amend their personal information that they believe is incomplete or inaccurate. If we did not create the information, we will refer Cigna-HealthSpring’s member to the source of the information.

• Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to their home address could endanger them.

• Receive an accounting of Cigna-HealthSpring’s disclosures of their medical information, except when those disclosures are for treatment, payment or health care operations, or the law otherwise restricts the accounting.

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws in order to protect member PHI. To discuss any breaches of the privacy of our members, please contact our HIPAA Privacy Officer at 1-615-236-6157.

Member Rights and Responsibilities

Cigna-HealthSpring members have the following rights: The right to be treated with dignity and respect

Members have the right to be treated with dignity, respect, and fairness at all times. Cigna-HealthSpring must obey laws against discrimination that protect members from unfair treatment. These laws say that Cigna-HealthSpring cannot discriminate against members (treat members unfairly) because of a person’s race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. If members need help with communication,
such as help from a language interpreter, they should be directed to call Member Services. Member Services can also help members in filing complaints about access to facilities (such as wheelchair access). Members can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or the Office for Civil Rights in their area for assistance.

The right to the privacy of medical records and personal health information

There are federal and state laws that protect the privacy of member medical records and personal health information. Cigna-HealthSpring keeps members’ personal health information private as required under these laws. Any personal information that a member gives Cigna-HealthSpring is protected. Cigna-HealthSpring staff will make sure that unauthorized people do not see or change member records. Generally, we will get written permission from the member (or from someone the member has given legal authority to make decisions on their behalf) before we can give member health information to anyone who is not providing the member’s medical care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect member privacy give them rights related to getting information and controlling how their health information is used. Cigna-HealthSpring is required to provide members with a notice that tells them about these rights and explains how Cigna-HealthSpring protects the privacy of their health information. For example, members have the right to look at their medical records, and to get copies of the records (there may be a fee charged for making copies). Members also have the right to ask plan providers to make additions or corrections to their medical records (if members ask plan providers to do this, they will review member requests and figure out whether the changes are appropriate). Members have the right to know how their health information has been given out and used for routine and non-routine purposes. If members have questions or concerns about privacy of their personal information and medical records, they should be directed to call Member Services. Cigna-HealthSpring will release a member’s information, including prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The right to see participating providers, get covered services, and get prescriptions filled within a reasonable period of time.

Members will get most or all of their health care from participating providers, that is, from doctors and other health providers who are part of Cigna-HealthSpring. Members have the right to choose a participating provider (Cigna-HealthSpring will work with members to ensure they find physicians who are accepting new patients). Members have the right to go to a women’s health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their providers and to see specialists when care from a specialist is needed. Members also have the right to timely access to their prescriptions at any network pharmacy. “Timely access” means that members can get appointments and services within a reasonable amount of time. The Evidence of Coverage explains how members access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

The right to know treatment choices and participate in decisions about their health care

Members have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their health care. Cigna-HealthSpring providers must explain things in a way that members can understand. Members have the right to know about all of the treatment choices that are recommended for their condition including all appropriate and medically necessary treatment options, no matter what their cost or whether they are covered by Cigna-HealthSpring. This includes the right to know about the different Medication Management Treatment Programs Cigna-HealthSpring offers and those in which members may participate. Members have the right to be told about any risks involved in their care. Members must be told in advance if any proposed medical care or treatment is part of a research experiment and be given the choice of refusing experimental treatments.

Members have the right to receive a detailed explanation from Cigna-HealthSpring if they believe that a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. “Initial decisions” are discussed in the members’ Evidence of Coverage.

Members have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. This also includes the right to stop taking their medication. If members refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

The right to use advance directives (such as a living will or a power of attorney)

Members have the right to ask someone such as a family member or friend to help them with decisions about their health care. Sometimes, people become
unable to make health care decisions for themselves due to accidents or serious illness. If a member wants to, he/she can use a special form to give someone they trust the legal authority to make decisions for them if they ever become unable to make decisions for themselves. Members also have the right to give their doctors written instructions about how they want them to handle their medical care if they become unable to make decisions for themselves. The legal documents that members can use to give their directions in advance of these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living wills” and “powers of attorney for health care” are examples of advance directives.

If members decide that they want to have an advance directive, there are several ways to get this type of legal form. Members can get a form from their lawyer, from a social worker, from Cigna-HealthSpring, or from some office supply stores. Members can sometimes get advance directive forms from organizations that give people information about Medicare. Regardless of where they get this form, keep in mind that it is a legal document. Members should consider having a lawyer help them prepare it. It is important to sign this form and keep a copy at home. Members should give a copy of the form to their doctor and to the person they name on the form as the one to make decisions for them if they can’t. Members may want to give copies to close friends or family members as well.

If members know ahead of time that they are going to be hospitalized and they have signed an advance directive, they should take a copy with them to the hospital. If members are admitted to the hospital, the hospital will ask them whether they have signed an advance directive form and whether they have it with them. If members have not signed an advance directive form or does not have a copy available during admission, the hospital has forms available and will ask if the member wants to sign one.

Remember, it is a member’s choice whether he/she wants to fill out an advance directive (including whether they want to sign one if they are in the hospital). According to law, no one can deny them care or discriminate against them based on whether or not they have signed an advance directive. If members have signed an advance directive and they believe that a doctor or hospital has not followed the instructions in it, Members may file a complaint with their State Board of Medicine or appropriate state agency (this information can be found in the member’s Evidence of Coverage).

The right to make complaints
Members have the right to make a complaint if they have concerns or problems related to their coverage or care. Members or an appointed/authorized representative may file “Appeals,” “grievances,” concerns and coverage determinations. If members make a complaint or file an appeal or coverage determination, Cigna-HealthSpring must treat them fairly (i.e., not discriminate against them) because they made a complaint or filed an appeal or coverage determination. To obtain information relative to appeals, grievances, concerns and/or coverage determinations, members should be directed to call Member Services.

The right to get information about their health care coverage and cost
The Evidence of Coverage tells members what medical services are covered and what they have to pay. If they need more information, they should be directed to call Member Services. Members have the right to an explanation from Cigna-HealthSpring about any bills they may get for services not covered by Cigna-HealthSpring. Cigna-HealthSpring must tell members in writing why Cigna-HealthSpring will not pay for or allow them to get a service and how they can file an appeal to ask Cigna-HealthSpring to change this decision. Staff should inform members on how to file an appeal, if asked, and should direct members to review their Evidence of Coverage for more information about filing an appeal.

The right to get information about Cigna-HealthSpring, plan providers, drug coverage, and costs
Members have the right to get information about the Cigna-HealthSpring plans and operations. This includes information about our financial condition, about the services we provide, and about our health care providers and their qualifications. Members have the right to find out from us how we pay our doctors. To get any of this information, Members should be directed to call Member Services. Members have the right to get information from us about their Part D prescription coverage. This includes information about our financial condition and about our network pharmacies. To get any of this information, staff should direct members to call Member Services.

The right to get more information about members rights
Members have the right to receive information about their rights and responsibilities. If members have questions or concerns about their rights and protections, they should be directed to call Member Services. Members can also get free help and information from their State Health Insurance Assistance Program.
(SHIP). In addition, the Medicare program has written a booklet called Members Medicare Rights and Protections. To get a free copy, members should be directed to call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Members can call 24 hours a day, 7 days a week. Or, members can visit www.medicare.gov on the web to order this booklet or print it directly from their computer.

The right to take action if a member thinks they have been treated unfairly or their rights are not being respected

If members think they have been treated unfairly or their rights have not been respected, there are options for what they can do.

• If members think they have been treated unfairly due to their race, color, national origin, disability, age, or religion, we must encourage them to let us know immediately. They can also call the Office for Civil Rights in their area.

• For any other kind of concern or problem related to their Medicare rights and protections described in this section, members should be encouraged to call Member Services. Members can also get help from their State Health Insurance Assistance Program (SHIP).

Cigna-HealthSpring members have the following responsibilities:

Along with certain rights, there are also responsibilities associated with being a member of Cigna-HealthSpring. Members are responsible for the following:

• To become familiar with their Cigna-HealthSpring coverage and the rules they must follow to get care as a member. Members can use their Cigna-HealthSpring Evidence of Coverage and other information that we provide them to learn about their coverage, what we have to pay, and the rules they need to follow. Members should always be encouraged to call Member Services if they have any questions or complaints.

• To advise Cigna-HealthSpring if they have other insurance coverage.

• To notify providers when seeking care (unless it is an emergency) that they are enrolled with Cigna-HealthSpring and present their plan enrollment card to the provider.

• To give their doctors and other providers the information they need to provide care for them and to follow the treatment plans and instructions that they and their doctors agree upon. Members must be encouraged to ask questions of their doctors and other providers whenever the member has them.

• To act in a way that supports the care given to other patients and helps the smooth running of their doctor’s office, hospitals, and other offices.

• To pay their plan premiums and any co-payments or coinsurances they may have for the Covered Services they receive. Members must also meet their other financial responsibilities that are described in their Evidence of Coverage.

• To let Cigna-HealthSpring know if they have any questions, concerns, problems, or suggestions regarding their rights, responsibilities, coverage, and/or Cigna-HealthSpring operations.

• To notify Cigna-HealthSpring Member Services and their providers of any address and/or phone number changes as soon as possible.

• To use their Cigna-HealthSpring plan only to access services, medications and other benefits for themselves.

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient’s right is to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. In accordance with guidelines established by the Centers for Medicare and Medicaid Services (CMS), HEDIS requirements, and our own policies and procedures, Cigna-HealthSpring requires all participating providers to have a process in place pursuant to the intent of the Patient Self Determination Act.

All providers contracted directly or indirectly with Cigna-HealthSpring may be informed by the member that the member has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record.

If the Primary Care Physician (PCP) and/or treating provider cannot as a matter of conscience fulfill the member’s written advance directive, he/she must advise the member and Cigna-HealthSpring. Cigna-HealthSpring and the PCP and/or treating provider will arrange for a transfer of care. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in The Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience.

To ensure providers maintain the required processes to Advance Directives, Cigna-HealthSpring
conducts periodic patient medical record reviews to confirm that required documentation exists.

**Benefits and Services**

All Cigna-HealthSpring members receive benefits and services as defined in their Evidence of Coverage (EOC). Each month, Cigna-HealthSpring makes available to each participating Primary Care Physicians a list of their active members. Along with the member’s demographic information, the list includes the name of the Plan in which the member enrolled. Please be aware that recently-terminated members may appear on the list. (See “Eligibility Verification” section of this manual).

Cigna-HealthSpring encourages its members to call their Primary Care Physician to schedule appointments. However, if a Cigna-HealthSpring member calls or comes to your office for an unscheduled non-emergent appointment, please attempt to accommodate the member and explain to them your office policy regarding appointments. If this problem persists, please contact Cigna-HealthSpring.

**Emergency Services and Care After Hours**

**Emergency Services**

An emergency is defined by Cigna-HealthSpring as the sudden onset of a medical condition with acute symptoms. A member may reasonably believe that the lack of immediate medical attention could results in:

- Permanently placing the member’s health in jeopardy
- Causing serious impairments to body functions
- Causing serious or permanent dysfunction of any body organ or part

In the event of a perceived emergency, members have been instructed to first contact their Primary Care Physician for medical advice. However, if the situation is of such a nature that it is life threatening, members have been instructed to go immediately to the nearest emergency room facility. Members who are unable to contact their PCP prior to receiving emergency treatment have been instructed to contact their PCP as soon as is medically possible or within forty-eight (48) hours after receiving care. The PCP will be responsible for providing and arranging any necessary follow-up services.

For emergency services within the service area, the PCP is responsible for providing, directing, or authorizing a member’s emergency care. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to assist members needing emergency services. The hospital may attempt to contact the PCP for direction. Members have a co-payment responsibility for outpatient emergency visits unless an admission results.

**Urgent Services**

Urgent Care services are for the treatment of symptoms that are non-life threatening but that require immediate attention. The member must first attempt to receive care from his/her PCP. Treatment at a participating Urgent Care Center will be covered by Cigna-HealthSpring without a referral.

**Continue or Follow-up Treatment**

Continuing or follow-up treatment, except by the PCP, whether in or out of service area, is not covered by Cigna-HealthSpring unless specifically authorized or approved by Cigna-HealthSpring. Payment for covered benefits outside the service area is limited to medically necessary treatment required before the member can reasonably be transported to a participating hospital or returned to the care of the PCP.

**Excluded Services**

In addition to any exclusion or limitations described in the members’ EOC, the following items and services are not covered under the Original Medicare Plan or by Cigna-HealthSpring:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our plan and the Original Medicare Plan to not be generally accepted by the medical community.
- Surgical treatment of morbid obesity unless medically necessary or covered under the Original Medicare Plan
- Private room in a hospital, unless medically necessary
- Private duty nurses

For emergency services outside the service area, Cigna-HealthSpring will pay reasonable charges for emergency services received from non-participating providers if a member is injured or becomes ill while temporarily outside the service area. Members may be responsible for a co-payment for each incident of outpatient emergency services at a hospital’s emergency room or urgent care facility.
• Personal convenience items, such as a telephone or television in a member’s room at a hospital or skilled nursing facility
• Nursing care on a full-time basis in a member’s home
• Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating, and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.

• Homemaker services
• Charges imposed by immediate relatives or members of the member’s household
• Meals delivered to the member’s home
• Elective or voluntary enhancement procedures, services, supplies, and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance unless medically necessary

• Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
• Routine dental care (i.e. cleanings, fillings, or dentures) or other dental services unless otherwise specified in the EOC. However, non-routine dental services received at a hospital may be covered.

• Chiropractic care is generally not covered under the plan with the exception of manual manipulation of the spine and is limited according to Medicare guidelines.
• Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.

• Orthopedic shoes unless they are part of a leg brace and included in the cost of the brace. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
• Supportive devices for the feet. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

• Hearing aids and routine hearing examinations unless otherwise specified in the EOC
• Eyeglasses, with the exception of after cataract surgery, routine eye examinations, racial keratotomy, LASIK surgery, vision therapy and other low vision aids and services unless otherwise specified in the EOC

• Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasm or hyporgasm unless otherwise included in the member’s Part D benefit. Please see the formulary for details.
• Reversal of sterilization measures, sex change operations, and non-prescription contraceptive supplies
• Acupuncture
• Naturopath services
• Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency situations received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under the plan, the plan will reimburse veterans for the difference. Members are still responsible for our plan cost-sharing amount.

• Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Grievance and Appeal Process

All telephone complaints received by Cigna-HealthSpring’s Medicare Advantage Customer Service department will be resolved on an informal basis, except for complaints that involve “appealable” issues. These appealable issues will be placed in either the expedited or standard appeals process. In situations where a member remains dissatisfied with the informal resolution, the member must submit in writing a request for reconsideration of the informal resolution. All other written letter of complaint received by Cigna-HealthSpring will be logged in our tracking system and automatically placed within either the appeal or grievance process, whichever is appropriate.

Members of Cigna-HealthSpring have the right to file a complaint, also called a grievance, about problems they observe or experience with the health plan. Situations for which a grievance may be filed include but are not limited to:

• Complaints about services in an optional Supplementary Benefit package
• Complaints regarding issues such as waiting times, physician behavior or demeanor, and adequacy of facilities and other similar member concerns
• Involuntary disenrollment situations
• Complaints concerning the quality of services a member receives
Members of Cigna-HealthSpring have the right to appeal any decision about Cigna-HealthSpring’s failure to provide what they believe are benefits contained in the basic benefit package. These include:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide
- A denied claim for any other health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by Cigna-HealthSpring
- Services they have not received, but believe are the responsibility of Cigna-HealthSpring to pay for
- A reduction in or termination of service a member feels are medically necessary

In addition, a member may appeal any decision to discharge them from the hospital. In this case, a notice will be given to the member with information about how to appeal and will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review.

Please refer to the Cigna-HealthSpring Evidence of Coverage (EOC) for additional information.

**Dual Eligible Members**

Many of your patients may have Cigna-HealthSpring as their primary insurance payer and Medicaid as their secondary payer. This will require you to coordinate the benefits of these “dual eligible” Cigna-HealthSpring Members by determining whether the member should be billed for the deductibles and co-payments, or coinsurances associated with their benefit plan. Providers may not assess a QMB (Qualified Medicare Beneficiary) or QMB-Plus for Cigna-HealthSpring co-payments, coinsurances, and/or deductibles.

Providers will accept as payment in full Cigna-HealthSpring’s payment and will not seek additional payment from the State or dual eligible members. Additional information concerning Medicaid provider participation is available at: [www.cignahealthspring.com](http://www.cignahealthspring.com) and [www.hhsc.state.tx.us/medicaid/index.html](http://www.hhsc.state.tx.us/medicaid/index.html)

A member’s level of Medicaid eligibility can change due to their medical and financial needs. Cigna-HealthSpring encourages you to verify members’ Medicaid eligibility when rendering services which will help you determine if the member owes a deductible or co-pay.

Medicaid eligibility can be obtained by using the Medicaid telephonic Eligibility Verification System. If you do not have access to the system, please contact your State Medicaid provider for additional information.

Please note, each state varies in their decision to cover the cost-share for populations beyond QMB and QMB+

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**Cigna-HealthSpring Cost-Sharing Chart**

<table>
<thead>
<tr>
<th>Patient’s Medicaid Plan</th>
<th>Patient’s Liability</th>
<th>Medicaid Provides Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Owes Deductibles &amp; Copayments associated with Benefit Plan</td>
<td>Patient not liable for Deductibles &amp; Copayments associated with Benefit Plan</td>
</tr>
<tr>
<td>Medicaid (FBDE)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>QMB Only</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>QMB+</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>SLMB</td>
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<td>No</td>
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<tr>
<td>SLMB+</td>
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<td>No</td>
</tr>
<tr>
<td>QI-1</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>QDWI</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Medicaid Coverage Groups**

**Full Benefit Dual Eligibles (FBDE)**

An individual who is eligible for Medicaid either categorically or through optional coverage groups such as medically-needy or special income levels for institutionalized or home and community-based waivers, but who does not meet the income or resource criteria for QMB or SLMB.

**Qualified Medicare Beneficiary (QMB Only)**

A “QMB” is an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, co-insurance, and co-payments (except for Part D). QMBs who do not qualify for any additional Medicaid Benefits are called “QMB Only”. Providers may not assess a QMB for Cigna-HealthSpring deductibles, co-payments, or coinsurances.

**Qualified Medicare Beneficiary Plus (QMB+)**

An individual who meets standards for QMB eligibility and also meets criteria for full Medicaid benefits in the State. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or through spending down excess income to the Medically Needy level.

**Specified Low-income Medicare Beneficiary (SLMB Only)**

A “SLMB” is an individual who is entitled to Medicare Part A, has income that exceeds 100% FPL but is less than 120% FPL, and whose resources do not exceed twice the SSI limit. The only Medicaid benefit for which a SLMB is eligible is payment of Medicare Part B premiums. SLMBs who do not qualify for any additional Medicaid benefits are called “SLMB Only”.

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8
Specified Low-Income Medicare Beneficiary Plus (SLMB+)

An individual who meets the standards for SLMB eligibility, but who also meets the criteria for full State Medicaid benefits. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits. These individuals often qualify for Medicaid by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.

Qualifying Individual (QI)

A “QI” is an individual who is entitled to Part A, has income that is at least 120% FPL but less than 135% FPL, resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. A QI is similar to a SLMB in that the only benefit available is Medicaid payment of the Medicare Part B premium; however, expenditures for QIs are 100% federally funded and the total expenditures are limited by statute.

Other Full Benefit Dual Eligibles (FBDE)

An individual who is eligible for Medicaid either categorically or through optional coverage groups such as medically-needy or special income levels for institutionalized or home and community-based waivers, but who does not meet the income or resource criteria for QMB or SLMB.

Qualified Disabled and Working Individual (QDWI)

A QDWI is an individual who lost Medicare Part A benefits due to returning to work, but who is eligible to enroll in and purchase Medicare Part A. The individual’s income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. QDWIs are eligible only for Medicaid payment of Part A premiums.

Coordination of Care with STAR+PLUS Medicaid

The State of Texas’ goal for managed Medicaid services is to integrate acute care and Long Term Services and Supports, including services provided through Medicare Advantage Dual Special Needs Plans (MA-Dual SNP); provide continuity of care; and ensure timely access to quality care through an adequate provider network that includes behavioral health services and disease management services.

The term “dual eligible” refers to someone who is enrolled in both Medicaid and Medicare. Some dual eligible clients are eligible for STAR+PLUS. Dual eligible clients must choose a STAR+PLUS MCO, but do not choose a PCP because they receive acute care services from their Medicare providers. The STAR+PLUS MCO covers only Long-Term Services and Supports (LTSS) for dual eligible members.

Certain Medicaid clients are excluded from enrolling in STAR+PLUS. This includes:

- Residents of nursing facilities.
- STAR+PLUS HMO members who have been in a nursing facility for more than 4 months.
- Clients of Medicaid 1915(c) waiver services other than Community-Based Alternatives services.
- Clients not eligible for full Medicaid benefits, such as Frail Elderly program members, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualified Disabled Working Individuals and undocumented aliens.
- Children in state foster care.
- People not eligible for Medicaid
- Undocumented immigrants.

In service areas where STAR+PLUS is available, members are eligible for Community-Based Long-Term Care Services and Supports through their STAR+PLUS MCO.

Long-term Care Services available to all STAR+PLUS members include:

- Providers offering Personal Attendant Services (PAS) assist members with the performance of activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment. The level of assistance provided is determined by the member’s needs and plan of care. Services may also include the provision of nursing tasks delegated by a registered nurse in accordance with state rules promulgated by the Texas Board of Nursing, and protective supervision provided solely to ensure the health and welfare of a member with cognitive/memory impairment and/or physical weakness.
- Day Activity and Health Services (DAHS) include nursing and personal care services, physical rehabilitation services, nutrition services, transportation services, and other supportive services. These services are offered by facilities licensed by the Texas Department of Human Services and certified by Texas Department of Aging and Disability Services. Except for holidays, these facilities must have services available at least 10 hours a day, Monday through Friday.

Long-term Care Services Available to STAR+PLUS members who qualify under the HCBs STAR+PLUS Waiver (SPW) (previously known as 1915 (c) Nursing Facility Waiver Program):
Adaptive Aids
Adaptive aids and medical equipment include devices, controls, or medically necessary supplies that enable members with functional impairments to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. A complete listing of covered adaptive aids and medical equipment is available in the STAR+PLUS Handbook which is available at www.dads.state.tx.us/handbooks/sph

Adult Foster Care
Adult foster care is a 24-hour living arrangement in a Department of Human Services (DHS) foster home for people who, because of physical or mental limitations, are unable to continue residing in their own homes. Services may include meal preparation, housekeeping, personal care, help with activities of daily living, supervision, and the provision or arrangement of transportation;

Assisted Living
Assisted living (AL) is a twenty-four (24) hour living arrangement in a licensed personal care facility in which personal care, home management, escort, social and recreational activities, twenty-four (24) hour supervision, supervision of, assistance with, and direct administration of medications, and the provision or arrangement of transportation are provided. Under the HCBS STAR+PLUS Waiver (SPW), personal care facilities may contract to provide services in two distinct types of living arrangements: (1) assisted living apartments, (2) assisted living non-apartment settings.

Dental Services
The services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include emergency dental treatment necessary to control bleeding, relieve pain and eliminate acute infection; preventive procedures required to prevent the imminent loss of teeth; the treatment of injuries to teeth or supporting structures; dentures and the cost of preparation and fitting; and routine procedures necessary to maintain good oral health.

Emergency Response Services
Emergency Response Services (ERS) are electronic monitoring systems for use by functionally impaired individuals who live alone or are isolated in the community. In an emergency, the member can press a call button to signal for help. The electronic monitoring system, which has a twenty-four (24) hour, seven (7) day per week capability, helps ensure that the appropriate persons or service agency responds to an alarm call from the member;

Financial Management Services
Assistance to members with managing funds associated with services elected for self-direction and is provided by the consumer directed services agency. This service includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers.

Home Delivered Meals
Home delivered meals are provided to people who are unable to prepare their own meals and for whom there are no other persons available to do so or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet the member’s individual requirements;

Home Modifications
Minor home modifications are services that assess the need for, arrange for, and provide modifications and/or improvements to an individual’s residence to enable them to reside in the community and to ensure safety, security and accessibility;

Medical Supplies
Medical supplies not available under the 1915(b) Waiver Program;

Nursing Services
In-home Nursing Services include, but are not limited to, assessing and evaluating health problems and the direct delivery of nursing tasks, providing treatments and health care procedures ordered by a physician and/or required by standards of professional practice or state law, delegating nursing tasks to unlicensed persons according to state rules promulgated by the Texas Board of Nursing, developing the health care plan and teaching members about proper health maintenance;

Respite Services
Respite Services offer temporary relief to persons caring for functionally impaired adults in community settings other than Adult Foster Care (AFC) homes or Assisted Living /Residential Care (AL/RC) facilities. Respite services are provided on an in-home basis and out-of-home basis and are limited to thirty (30) days per year. Room and board is included in the Waiver Program payment for out-of-home settings;

Support Consultation
Support Consultation is an optional service component that offers practical skills training and assistance to enable an individual to successfully direct those services the individual elects for participant-direction. This service is provided by a certified support advisor, and includes skills training related to recruiting, screening, and hiring workers, preparing
job descriptions, verifying employment eligibility and qualifications, completion of documents required to employ an individual, management of workers, and development of effective back-up plans for services considered critical to the individual’s health and welfare in the absence of the regular provider or an emergency situation. Support consultation is provided only by a certified support advisor certified by the Department of Aging and Disability

**Therapy Services**

- Physical therapy includes specialized techniques for the evaluation and treatment of chronic conditions related to functions of the neuro-musculo-skeletal systems. Services include the full range of activities provided by a physical therapist or a licensed physical therapy assistant under the direction of a licensed physical therapist, within the scope of the therapist’s state licensure.

- Occupational therapy includes interventions and procedures for chronic conditions to promote or enhance safety and performance in instrumental activities of daily living, education, work, play, leisure and social participation. Services include the full range of activities provided by an occupational therapist or a licensed occupational therapy assistant under the direction of a licensed occupational therapist, within the scope of the therapist’s state licensure.

- Speech therapy includes evaluation and treatment of impairments, disorders or deficiencies related to a member’s speech and language which are chronic conditions. Services include the full range of activities provided by speech and language pathologists under the scope of their state licensure; and

**Transition Assistance Services (TAS)**

Offers a maximum of $2,500 to enhance the ability of nursing facility residents to transition and receive services in the community. TAS helps defray the costs associated with setting up a household for those members establishing an independent residence. TAS include, but are not limited to, payment of security deposits to lease an apartment, purchase of essential furnishings (table, eating utensils), payment of moving expenses, etc.

**Continuity of Care**

Cigna-HealthSpring’s policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services.

When a practitioner leaves Cigna-HealthSpring’s network and a member is in an active course of treatment, our Health Services staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time. In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter. Members in their second or third trimester of pregnancy have access to the exiting provider through the postpartum period.

If the plan terminates a participating provider, Cigna-HealthSpring will work to transition a member into care with a Participating Physician or other provider within Cigna-HealthSpring’s network. Cigna-HealthSpring is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

Cigna-HealthSpring also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in Cigna-HealthSpring’s network. Under these circumstances, Cigna-HealthSpring will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment. Cigna-HealthSpring will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) initiated prior to a new member’s enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care.

**PROVIDER INFORMATION**

**Providers Designated as Primary Care Physicians (PCPs)**

Cigna-HealthSpring recognizes Family Medicine, General Practice, Geriatric Medicine, and Internal Medicine physicians as Primary Care Physicians (PCPs).

Cigna-HealthSpring may recognize Infectious Disease Physicians as PCPs for members who may require a specialized physician to manage their specific health care needs.

All contracted credentialed providers participating with Cigna-HealthSpring are listed in the region-appropriate Provider Directory, which is provided to members and made available to the public.
The Role Of The Primary Care Physician (PCP)

Each Cigna-HealthSpring member must select a Cigna-HealthSpring Participating Primary Care Physician (PCP) at the time of enrollment. The PCP is responsible for managing all the health care needs of a Cigna-HealthSpring member as follows:

- Manage the health care needs of Cigna-HealthSpring members who have chosen the physician as their PCP;
- Ensure that members receive treatment as frequently as is necessary based on the member’s condition;
- Develop an individual treatment plan for each member;
- Submit accurately and timely claims and encounter information for clinical care coordination;
- Comply with Cigna-HealthSpring’s pre-authorization and referral procedures;
- Refer members to appropriate Cigna-HealthSpring participating providers;
- Comply with Cigna-HealthSpring’s Quality Management and Utilization Management programs;
- Participate in Cigna-HealthSpring’s 360 Assessment Program;
- Use appropriate designated ancillary services;
- Comply with emergency care procedures;
- Comply with Cigna-HealthSpring access and availability standards as outlined in this manual, including after-hours care;
- Bill Cigna-HealthSpring on the CMS 1500 claim form or electronically in accordance with Cigna-HealthSpring’s billing procedures;
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a member’s condition and ensure that the codes submitted are supported by proper documentation in the medical record;
- Comply with Preventive Screening and Clinical Guidelines;
- Adhere to Cigna-HealthSpring’s medical record standards as outlined in this manual.

Administrative, Medical and/or Reimbursement Policy Changes

From time to time, Cigna-HealthSpring may amend, alter, or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards, and modification of Covered Services. Specific Cigna-HealthSpring policies and procedures may be obtained by calling our Provider Services Department at 1-800-230-6138.

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

- Annual Provider Manual Updates
- Letter
- Facsimile
- Email
- Provider Newsletters

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

Communication Among Providers

- The PCP should provide the Specialist Physician with relevant clinical information regarding the member's care.
• The Specialist Physician must provide the PCP with information about his/her visit with the member in a timely manner.
• The PCP must document in the member’s medical record his/her review of any reports, labs, or diagnostic tests received from a Specialist Physician.

Provider Marketing Guidelines

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

Provider Can:
• Mail/call their patient panel to invite patients to general Cigna-HealthSpring sponsored educational events to learn about the Medicare and/or Medicare Advantage program. This is not a sales/marketing meeting. No sales representative or plan materials can be distributed. Sales representative cards can be provided upon request.
• Mail an affiliation letter one time to patients listing only Cigna-HealthSpring.
• Have additional mailings (unlimited) to patients about participation status but must list all participating Medicare Advantage plans and cannot steer towards a specific plan. This letter may not quote specific plan benefits without prior CMS approval and the agreement of all plans listed.
• Notify patients in a letter of a decision to participate in a Cigna-HealthSpring sponsored programs.
• Utilize a physician/patient newsletter to communicate information to patients on a variety of subjects. This newsletter can have a Cigna-HealthSpring corner to advise patients of Cigna-HealthSpring information.
• Provide objective information to patients on specific plan formularies, based on a patient’s medications and health care needs.
• Refer patients to other sources of information, such as the State Health Insurance Assistance Programs, Cigna-HealthSpring marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making a healthcare enrollment decision.
• Display and distribute in provider offices Cigna-HealthSpring MA and MAPD marketing materials, excluding application forms. The office must display or offer to display materials for all participating MA plans.
• Notify patients of a physician’s decision to participate exclusively with Cigna-HealthSpring for Medicare Advantage or to close panel to original Medicare FFS if appropriate.
• Record messages on our auto dialer to existing Cigna-HealthSpring members as long as the message is not sales related or could be construed as steerage. The script must be reviewed by Cigna-HealthSpring Legal /Government Programs.
• Have staff dressed in clothing with the Cigna-HealthSpring logo.
• Display promotions items with the Cigna-HealthSpring logo.
• Allow Cigna-HealthSpring to have a room/space in provider offices completely separate from where patients have a prospect of receiving health care, to provide beneficiaries access to a Cigna-HealthSpring sales representative.

Provider Cannot:
• Quote specific health plan benefits or cost share in patient discussions.
• Urge or steer towards any specific plan or limited set of plans.
• Collect enrollment applications in physician offices or at other functions.
• Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
• Health Screen potential enrollees when distributing information to patients, as health screening is prohibited.
• Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
• Call members who are disenrolling from the health plan to encourage re-enrollment in a health plan.
• Mail notifications of health plan sales meetings to patients.
• Call patients to invite patients to sales and marketing activity of a health plan.
• Advertise using Cigna-HealthSpring’s name without Cigna-HealthSpring’s prior consent and potentially CMS approval depending upon the content of the advertisement.
Member Assignment To New PCP

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

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

The provider should make reasonable efforts to address the member’s behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists.

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

Cigna-HealthSpring will research the concern and decide if the situation warrants requesting a new PCP assignment. If so, Cigna-HealthSpring will document all actions taken by the provider and Cigna-HealthSpring to cure the situation. This may include member education and counseling.

A Cigna-HealthSpring PCP cannot request a disenrollment based on adverse change in a member’s health status or utilization of services medically necessary for treatment of a member’s condition.

Procedure

1. Once Cigna-HealthSpring has reviewed the PCP’s request and determined that the physician/patient relationship has been irreparably harmed, the member will receive a minimum of thirty (30) days notice that the physician/patient relationship will be ending. Notification must be in writing, by certified mail and Cigna-HealthSpring must be copied on the letter sent to the patient.

2. The physician will continue to provide care to the member during the thirty (30) day period or until the member selects or is assigned to another physician. Cigna-HealthSpring will assist the member in establishing a relationship with another physician.

3. The physician will transfer, at no cost, a copy of the medical records of the member to the new PCP and will cooperate with the member’s new PCP in regards to transitioning care and providing information regarding the member’s care needs.

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

Providers must be contracted with and credentialed by Cigna-HealthSpring according to the following guidelines:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Status</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>New to plan and not previously credentialed</td>
<td>Practicing in a solo practice</td>
<td>Requires a signed contract and initial credentialing</td>
</tr>
<tr>
<td>New to plan and not previously credentialed</td>
<td>Joining a participating group practice</td>
<td>Requires initial credentialing</td>
</tr>
<tr>
<td>Already participating and credentialed</td>
<td>Leaving a group practice to begin a solo practice</td>
<td>Does not require credentialing; however a new contract is required and the previous group practice affiliation is terminated</td>
</tr>
<tr>
<td>Already participating and credentialed</td>
<td>Leaving a participating group practice to join another participating group practice</td>
<td>Does not require credentialing yet the group practice affiliation will be amended</td>
</tr>
<tr>
<td>Already participating and credentialed</td>
<td>Leaving a participating group practice to join a non-participating group practice</td>
<td>The provider’s participation is terminated unless the non-participating group signs a contract with Cigna-HealthSpring. Credentialing is still valid until re-credentialing due date</td>
</tr>
</tbody>
</table>

Plan Notification Requirements For Providers

Participating providers must provide written notice to Cigna-HealthSpring no less than 60 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter.

The following is a list of changes that must be reported to Cigna-HealthSpring by contacting your Network Operation Representative or Customer Service:

- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliations
- Practice name
- Providers joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence
- Practice mergers and/or acquisitions
- Adding or closing a practice location
- Tax Identification Number (please include W-9 form)
- NPI number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations

By providing this information in a timely manner, you will ensure that your practice is listed correctly in the provider directory. Please note, failure to provide up to date and correct information regarding demographic information regarding your practice and the physicians that participate may result in the denial of claims for you and your physicians.

Closing Patient Panels

When a Participating Primary Care Physician elects to stop accepting new patients, the provider’s patient panel is considered closed. If a Participating Primary Care Physician closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against Cigna-HealthSpring members by closing their patient panels for Cigna-HealthSpring members only, nor may they discriminate among Cigna-HealthSpring members by closing their panel to certain product lines. Providers who decide that they will no longer accept any new patients must notify Cigna-HealthSpring’s Network Management Department, in writing, at least 30 days before the date on which the patient panel will be closed or the time frame specified in your contract.

Medical Record Standards

Cigna-HealthSpring requires the following items in member medical records:

- Identifying information of the member
- Identification of all providers participating in the member’s care and information on services furnished by these providers
- A problem list, including significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses, and treatment plans
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)
- Information on advanced directives
- Past medical history, physical examinations, necessary treatments, and possible risk factors for the member relevant to the particular treatment.
Access and Availability Standards For Providers

A Primary Care Physician (PCP) must have their primary office open to receive Cigna-HealthSpring members five (5) days and for at least 20 hours per week. The PCP must ensure that coverage is available 24 hours a day, seven days a week. PCP offices must be able to schedule appointments for Cigna-HealthSpring members at least two (2) months in advance of the appointment. A PCP must arrange for coverage during absences with another Cigna-HealthSpring participating provider in an appropriate specialty which is documented on the Provider Application and agreed upon in the Provider Agreement.

Primary Care Access Standards

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-Urgent/Non-Emergent</td>
<td>Within one (1) week</td>
</tr>
<tr>
<td>Routine and Preventive</td>
<td>Within 30 Business Days</td>
</tr>
<tr>
<td>On-Call Response (After Hours)</td>
<td>Within 30 minutes for emergency</td>
</tr>
<tr>
<td>Waiting Time in Office</td>
<td>30 minutes or less</td>
</tr>
</tbody>
</table>

Specialist Access Standards

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-Urgent/Non-Emergent</td>
<td>Within one (1) week</td>
</tr>
<tr>
<td>Elective</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>High Index of Suspicion of Malignancy</td>
<td>Less than seven (7) days</td>
</tr>
</tbody>
</table>

Behavioral Health Access Standards

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Within 6 hours of the referral</td>
</tr>
<tr>
<td>Urgent/Symptomatic</td>
<td>Within 48 hours of the referral</td>
</tr>
<tr>
<td>Routine</td>
<td>Within ten (10) business days of the referral*</td>
</tr>
</tbody>
</table>

*Revised 03/2013

After-Hours Access Standards

All participating providers must return telephone calls related to medical issues. Emergency calls must be returned within 30 minutes of the receipt of the telephone call. Non-emergency calls should be returned within a 24-hour time period. A reliable 24 hours a day/7 days a week answering service with a beeper or paging system and on-call coverage arranged with another participating provider of the same specialty is preferred.

Physician Rights and Responsibilities

Physician Rights:

- Cigna-HealthSpring encourages your feedback and suggestions on how service may be improved within the organization.
- If an acceptable patient-physician relationship cannot be established with a Cigna-HealthSpring member who has selected you as his/her primary care physician, you may request that Cigna-HealthSpring have that member removed from your care.
- You may appeal any claims submissions in which you feel are not paid according to medical policy or in keeping with the level of care rendered.
- You may request to discuss any referral request with the Medical Director or Chief Medical Officer after various times in the review process, before a decision is rendered or after a decision is rendered.

Physician Responsibilities:

- You have agreed to treat Cigna-HealthSpring members the same as all other patients in your practice, regardless of the type or amount of reimbursement.
- Specialists must provide specialty services listed on the referral from the Primary Care Physician.
- Primary Care Physicians shall use best efforts to provide patient care to new members within four (4) months of enrollment with Cigna-HealthSpring.
- Primary Care Physicians shall use best efforts to provide follow-up patient care to members that have been in the hospital setting within ten (10) days of hospital discharge.
- Primary Care Physicians are responsible for the coordination of routine preventive care along with any ancillary services that need to be rendered with authorization.
- All providers are required to code to the highest level of specificity necessary to fully describe a member's acuity level. All coding should be conducted in accordance with CMS guidelines and all applicable state and federal laws.
- Specialists must provide specialty services up on referral from the Primary Care Physician and work closely with the referring physician regarding the treatment the member is to receive. Specialists must also provide continuous 24 hour, 7 days a week access to care for Cigna-HealthSpring members.
- Specialists are required to coordinate the referral process (i.e. obtain authorizations) for the further care that they recommend. This responsibility does not revert back to the Primary
Care Physician while the care of the member is under the direction of the Specialist.

- In the event you are temporarily unavailable or unable to provide patient care or referral services to a Cigna-HealthSpring member, you must arrange for another physician to provide such services on your behalf. This coverage cannot be provided by an Emergency Room.
- You have agreed to treat Cigna-HealthSpring members the same as all other patients in your practice, regardless of the type of amount of reimbursement.
- You have agreed to provide continuing care to participating members.
- You have agreed to utilize Cigna-HealthSpring’s participating physicians/facilities when services are available and can meet your patient’s needs. Approval prior to referring outside of the contracted network of providers may be required.
- You have agreed to participate in Cigna-HealthSpring’s peer review activities as they relate to the Quality Management/Utilization Review program.
- You may not balance bill a member for providing services that are covered by Cigna-HealthSpring. This excludes the collection of standard co-pays. You may bill a member for a procedure that is not a covered benefit if you have followed the appropriate procedures outlined in the Claims section of this manual.
- All claims must be received within the timeframe specified in your contract.

**Delegation**

Delegation is a formal process by which Cigna-HealthSpring enters into a written contract with an entity to provide administrative or health care services on behalf of a Medicare eligible member. A function may be fully or partially delegated.

Full delegation allows all activities of a function to be delegated. Partial delegation allows some of the activities to be delegated. The decision of what function may be considered for delegation is determined by the type of participation agreement a provider group has with Cigna-HealthSpring, as well as the ability of the provider group to perform the function. Contact the local Cigna-HealthSpring provider representative for detailed information on delegation.

Although Cigna-HealthSpring can delegate the authority to perform a function, it cannot delegate the responsibility.

Delegated providers must comply with the responsibilities outlined in the Delegated Services Agreement.

**HS CONNECT**

**Experience the Ease of HSConnect**

- View Member Eligibility
- Create Referrals
- Create Precertifications
- Search Authorizations
- Search Claims

**Provision of Health Care Services**

Participating providers shall provide health care services to all members, consistent with the benefits covered in their policy, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment or any other bases deemed unlawful under federal, state, or local law.
CREDENTIALING AND REcredentialing Program

All practitioner and organizational applicants to Cigna-HealthSpring must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider. Once an application has been submitted, the provider is subject to a rigorous verification process that includes primary and secondary source verifications of all applicable information for the contracted specialty(s). Upon completion of the verification process, providers are subject to a peer review process whereby they are approved or denied participation with the Plan. No provider can be assigned a health plan effective date or be included in a provider directory without undergoing the credentialing verification and peer review process. All providers who have been initially approved for participation are required to recredential at least once every three years in order to maintain their participating status.

Practitioner Selection Criteria

Cigna-HealthSpring utilizes specific selection criteria to ensure that practitioners who apply to participate meet basic credentialing and contracting standards. At minimum these include, but are not limited to:

- Holds appropriate, current and unencumbered licensure in the state of practice as required by state and federal entities
- Holds a current, valid, and unrestricted federal DEA and state controlled substance certificate as applicable
- Is board certified or has completed appropriate and verifiable training in the requested practice specialty
- Maintains current malpractice coverage with limits commensurate with the community standard in which practitioner practices
- Participates in Medicare and has a Medicare number and/or a National Provider Identification number
• Has not been excluded, suspended and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program
• Is not currently opted out of Medicare
• Has admitting privileges at a participating facility as applicable

Application Process

1. Submit a completed State Mandated Credentialing application, CAQH Universal Credentialing Application form or CAQH ID, or the Plan's application with a current signed and dated Attestation and Consent and Release form that is less than 90 days old.

2. If any of the Professional Disclosure questions are answered yes on the application, supply sufficient additional information and explanations.

3. Provide appropriate clinical detail for all malpractice cases that are pending, or resulted in a settlement or other financial payment.

4. Submit copies of the following:
   - All current and active state medical licenses, DEA certificate(s) and state controlled substance certificate as applicable
   - Evidence of current malpractice insurance that includes the effective and expiration dates of the policy and term limits.
   - Five years of work history documented in a month/year format either on the application or on a current curriculum vitae. Explanations are required for any gaps exceeding six (6) months.
   - If a physician, current and complete hospital affiliation information on the application. If no hospital privileges and the specialty warrants hospital privileges, a letter detailing the alternate coverage arrangement(s) or the name of the alternate admitting physician should be provided.

Credentialing and Recredentialing Process

Once a Practitioner has submitted an application for initial consideration, Cigna-HealthSpring's Credentialing Department will conduct primary source verification of the applicant's licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action, and malpractice history by querying the National Practitioner Data Bank. The credentialing process generally takes up to ninety (90) days to complete, but can in some instances take longer. Once credentialing has been completed and the applicant has been approved, the Practitioner will be notified in writing of their participation effective date.

To maintain participating status, all practitioners are required to recredential at least every three (3) years. Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners will be notified of the need to submit recredentialing information at least 4 months in advance of their three year anniversary date. Three (3) separate attempts will be made to obtain the required information via mail, fax, email or telephonic request. Practitioners who fail to return recredentialing information prior to their recredentialing due date will be notified in writing of their termination from the network.

Office Site Evaluations

Office site surveys and medical record keeping practice reviews may be required when it is deemed necessary as a result of a patient complaint, quality of care issue and/or as otherwise mandated by state regulations. Practitioner offices will be evaluated in the following categories:

1. Physical Appearance and Accessibility
2. Patient Safety and Risk Management
3. Medical Record Management and Security of Information
4. Appointment Availability

Providers who fail to pass the area of the site visit specific to the complaint or who score less than 90% on the site evaluation overall will be required to submit a corrective action plan and make corrections to meet the minimum compliance score. A follow up site evaluation will be done within sixty (60) days of the initial site visit if necessary to ensure that the correction action has been implemented.

Practitioner Rights

• Review information obtained from any outside source to evaluate their credentialing application with the exception of references, recommendations or other peer-review protected information. The provider may submit a written request to review his/her file information at least thirty days in advance at which time the Plan will establish a time for the provider to view the information at the Plan’s offices.

• Right to correct erroneous information when information obtained during the credentialing process varies substantially from that submitted by the practitioner. In instances where there is a substantial discrepancy in the information, Credentialing will notify the provider in writing of the discrepancy within thirty (30) days of receipt of the information. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within thirty (30) days of notification.
Right to be informed of the status of their application upon request. A provider may request the status of the application either telephonically or in writing. The Plan will respond within two business days and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated committee review date, and approval status.

Organizational Provider Selection Criteria

When assessing organizational providers, Cigna-HealthSpring utilizes the following criteria:

- Must be in good standing with all state and federal regulatory bodies
- Has been reviewed and approved by an accrediting body
- If not accredited, can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meets other Plan criteria
- Maintains current professional and general liability insurance as applicable
- Has not been excluded, suspended and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program

Organizational Provider Application and Requirements

1. A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.
2. If responded Yes to any disclosure question in the application, an appropriate explanation with sufficient details/information is required.
3. Copies of all applicable state and federal licenses (i.e. facility license, DEA, Pharmacy license, etc).
4. Proof of current professional and general liability insurance as applicable
5. Proof of Medicare participation
6. If accredited, proof of current accreditation.
   Note: Current accreditation status is required for DME, Prosthetic/Orthotics, and non-hospital based high tech radiology providers who perform MRIs, CTs and/or Nuclear/PET studies.
7. If not accredited, a copy of any state or CMS site surveys that has occurred within the last three years including evidence that the organization successfully remediated any deficiencies identified during the survey.

Organizational Site Surveys

As part of the initial assessment, an on-site review will be required on all hospitals, skilled nursing facilities, free-standing surgical centers, home health agencies and inpatient, residential or ambulatory mental health or substance abuse centers that do not hold acceptable accreditation status or cannot provide evidence of successful completion of a recent state or CMS site survey. Any organizational provider may also be subject to a site survey as warranted subsequent to the receipt of a complaint.

Organizational providers who are required to undergo a site visit must score a minimum of 85% on the site survey tool. Providers who fall below acceptable limits will be required to submit a written Corrective Action Plan (CAP) within thirty (30) days and may be re-audited at minimum within sixty (60) days to verify specific corrective action items as needed. Providers who fail to provide an appropriate CAP or who are unable to meet minimum standards even after re-auditing will not be eligible for participation.

Credentialing – Accreditation for DME, Orthotics and Prosthetic Providers

All Durable Medical Equipment and Orthotics and Prosthetic providers are required by Medicare to be accredited by one of the 10 national accreditation organizations. The most current listing of these organizations can be found at [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizationsCMB.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizationsCMB.pdf)

Pharmacies who provide durable medical equipment but are exempt from the accreditation requirement under Public Law #111-148 which amended title XVII of the Social Security Act, must provide the following information with their initial application:

- Evidence the pharmacy has been enrolled with Medicare as a supplier of durable medical equipment, prosthetics, orthotics and suppliers and has been issued a provider number for at least 5 years;
- An attestation that the pharmacy has met all criteria under the above referenced amendment

SNF – Site Visit requirements

Organizational Site Surveys

As part of the initial assessment, an on-site review will be required on all hospitals, skilled nursing facilities, free-standing surgical centers, home health agencies and inpatient, residential or ambulatory mental health or substance abuse centers that do not hold acceptable accreditation status or cannot provide evidence of successful completion of a recent (within last 3 years) state or CMS site survey.
Skilled nursing facilities that have been fined or have had denial of new admissions due to deficiencies found during annual licensure or complaint surveys conducted within the last three years must report that activity with their initial or recredentialing application. Explanations will be required for each event along with confirmation from the state licensing entity that the corrective action plan was accepted and the facility is currently in compliance with Medicare participation requirements.

**Credentialing Committee/Peer Review Process**

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

**Non-Discrimination in the Decision Making Process**

Cigna-HealthSpring’s Credentialing Program is compliant with all guidelines from the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and State regulations as applicable. Through the universal application of specific assessment criteria, Cigna-HealthSpring ensures fair and impartial decision-making in the credentialing process. No provider shall be denied participation based solely on race, gender, age, religion, ethnic origin, sexual orientation, type of population served or for specializing in certain types of procedures.

**Provider Notification**

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

**Appeals Process & Notification of Authorities**

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

**Confidentiality of Credentialing Information**

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

**Ongoing Monitoring**

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

**Provider Directory**

To be included in Provider Directories or any other member information, providers must be fully credentialed and approved. Directory specialty designations must be commensurate with the education, training, board certification and specialty(s) verified and approved via the credentialing process. Any requests for changes or updates to the specialty information in the directory may only be approved by Credentialing.
CLAIMS

Claims Submission
While Cigna-HealthSpring prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact Cigna-HealthSpring Provider Services for assistance at 1-800-230-6138.

All completed claims forms should be forwarded to the address noted below:

Cigna-HealthSpring
PO Box 981804
El Paso, TX 79998

For Commercial claims:

Cigna-HealthSpring
PO Box 2888
Houston, TX 77252

Timely Filing
As a Cigna-HealthSpring participating provider, you have agreed to submit all claims within 90 days, or in accordance with the terms of your agreement, of the date of service. Claims submitted with dates of service beyond 90 days, or in accordance with the terms of your agreement are not reimbursable by Cigna-HealthSpring.

Claim Format Standards
Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is: https://www.cms.gov/manuals/downloads/clm104c12.pdf

Cigna-HealthSpring can only pay claims which are submitted accurately. The provider is at all times responsible for accurate claims submission. While Cigna-HealthSpring will make its best effort to inform the provider of claims errors, the claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, they must bill and be paid as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice, but who are in different specialties may bill and be paid without regard to their membership in the same group.

Claim Payment
Cigna-HealthSpring pays clean claims according to contractual requirements and The Centers for Medicare and Medicaid Services (CMS) guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, lack of data fields required by Cigna-HealthSpring or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term shall be consistent with the Clean Claim definition set forth in applicable federal or state law, including lack of required substantiating documentation for non-participating providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of Cigna-HealthSpring, the claim is not considered clean.

Offsetting
As a contracted Cigna-HealthSpring Provider, you will be informed of any overpayments or other payments you may owe us within 365 days of the date on the Explanation of Benefits or within the timeframe as noted in your Agreement. You will have thirty (30) days from receipt of notification seeking recovery to refund us. We will provide you with the Member’s name, Member’s identification number, Cigna-HealthSpring’s claim number, your patient account number, date of service, a brief explanation of the recovery request and the amount or the requested recovery. If you have not refunded us within the thirty (30) days recovery notice period, we will offset the recovery amounts identified in the initial notification, or in accordance with the terms of your Agreement.

Pricing
Original Medicare typically has market adjusted prices by code (i.e. CPT or HCPCS) for services that Original Medicare covers. However, there are occasions where Cigna-HealthSpring offers a covered benefit for which Medicare has no pricing. In order to expedite claims processing and payment in these situations, Cigna-HealthSpring will work to arrive at a fair market price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid. Cigna-HealthSpring requests that you make every effort to submit claims with standard coding. As described in this Manual and/or your Agreement, you retain your rights to submit a Request for Reconsideration if you feel the reimbursement was incorrect.
Claims Encounter Data

Providers who are being paid under capitation must submit claims in order to capture encounter data as required per your Cigna-HealthSpring Provider Agreement.

Explanation of Payment (EOP)/Remittance Advice (RA)

The EOP/RA statement is sent to the provider after coverage and payment have been determined by Cigna-HealthSpring. The statement provides a detailed description of how the claim was processed.

Non Payment / Claim Denial

Any denials of coverage or non-payment for services by Cigna-HealthSpring will be addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed per each billed line if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the EOP/RA. Per your contract, the member may or may not be billed for services denied by Cigna-HealthSpring.

The member may not be billed for a covered service when the provider has not followed the Cigna-HealthSpring procedures. In some instances, providing the needed information may reverse the denial (i.e. referral form with a copy of the EOP / RA, authorization number, etc...). When no benefits are available for the member, or the services are not covered, the EOP/RA will alert you to this and you may bill the member.

Processing of Hospice Claims

When a Medicare Advantage (MA) member has been certified as hospice AND the premium Cigna-HealthSpring receives from The Centers for Medicare & Medicaid Services (CMS) is adjusted to hospice status, the financial responsibility for that member shifts from Cigna-HealthSpring to Original Medicare. While these two conditions exist, Original Medicare covers all Medicare-covered services rendered. The only services Cigna-HealthSpring is financially responsible for during this time include any benefits Cigna-HealthSpring offers above Original Medicare benefits that are non-hospice related, non-Medicare covered services such as vision (eyewear allowable), prescription drug claims, medical visit transportation, etc.

Until both conditions listed above have been met, Cigna-HealthSpring remains financially responsible for the member. Example: If a member is certified hospice on the 8th of the month, Cigna-HealthSpring continues to be financially responsible for that member until the end of that month. The financial responsibility shifts to Original Medicare on the 1st day of the following month; the date the CMS premium to Cigna-HealthSpring has been adjusted to hospice status for that member. These rules apply for both professional and facility charges.

ICD-10 Diagnosis and Procedure Code Reporting Begins October 1, 2014

In January 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the use of International Classification of Diseases version 10 (ICD-10) for diagnosis and hospital inpatient procedure coding. The rule impacts the health care industry – including health plans, hospitals, doctors and other health care professionals, as well as vendors and trading partners.

ICD-10 (International Classification of Diseases, 10th Edition, Clinical Modification / Procedure Coding System) consists of two parts:

- **ICD-10-CM** for Diagnosis coding is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 characters instead of the 3 to 5 characters used with ICD-9-CM, adding more specificity.
- **ICD-10-PCS** for Inpatient Procedure coding is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric characters instead of the 3 or 4 numeric characters used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

Note: Procedure codes are only applicable to claims and not prior authorizations.

The transition to ICD-10 is occurring because ICD-9 codes have limited data about patients’ medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT coding for outpatient procedures.
ICD-9 vs. ICD-10 Claim Submission Guidelines

Health care professionals must be prepared to comply with the transition to ICD-10 by October 1, 2014. Cigna-HealthSpring will strictly adhere to the following guidelines:

• All electronic transactions must use Version 5010 standards, which have been required since January 1, 2012. Unlike the older Version 4010/4010A standards, Version 5010 accommodates ICD-10 codes.

• Professional and outpatient claims submitted with a date of service or inpatient claims submitted with a discharge date prior to October 1, 2014 must be processed using ICD-9 codes.

• Professional and outpatient claims submitted with a date-of-service or inpatient claims submitted with a discharge date on or after October 1, 2014 must be processed using ICD-10 codes.

• Claims with ICD-9 codes for date of service or discharge provided on or after October 1, 2014 will be rejected.

• Claims with ICD-10 codes for date of service or discharge provided prior to October 1, 2014 will be rejected.

• Claims submitted with a mix of ICD-9 and ICD-10 codes will be rejected. Claims should be coded based on date of service (outpatient) or discharge date (inpatient).

• Some institutional claims, such as those for long-term or on-going care should be processed as split claims during the transition period. With such a split claim, all services rendered during a particular cycle before October 1, 2014 would be accounted for on one claim with ICD-9 codes. The other remaining services rendered on or after October 1, 2014 during that same cycle would be accounted for on a separate claim using ICD-10 codes.

• We can process claims after the compliance date with ICD-9 codes with dates of service or discharge dates prior to October 1, 2014, for a period of time to allow for claim run-off:

• Appeals with dates of service or discharge dates before October 1, 2014 should be submitted with the appropriate ICD-9 codes.

• Corrected or resubmitted claims with dates of service or discharge dates before October 1, 2014 should be submitted with the correct ICD-9 codes to the claim office for adjustment or correction.

Billable vs. Non-billable Codes

• A billable ICD-9 or ICD-10 code is defined as a code that has been coded to its highest level of specificity.

• A non-billable ICD-9 or ICD-10 code is defined as a code that has not been coded to its highest level of specificity. If a claim is submitted with a non-billable code, the claim will be rejected.

• The following are examples of billable ICD-9 codes with corresponding non-billable codes:

  - **Billable ICD-9 Codes**
    - 473.0 – Chronic maxillary sinusitis
    - 473 – Chronic sinusitis
  
  - **Non-billable ICD-9 Codes**
    - 474.00 – Chronic tonsillitis
    - 474 – Chronic disease of tonsils and adenoids

• The following is an example of a billable ICD-10 code with corresponding non-billable codes:

  - **Billable ICD-10 Code**
    - M1A.3110 – Chronic gout due to renal impairment, right shoulder, without tophus
  
  - **Non-billable ICD-10 Codes**
    - M1A.3 – Chronic gout due to renal impairment
    - M1A.31 – Chronic gout due to renal impairment, shoulder
    - M1A.311 – Chronic gout due to renal impairment, right shoulder

• It is acceptable to submit a claim using an unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.

  - **Unspecified ICD-9 Code**
    - 428.0 – Congestive heart failure, unspecified
    - 486 – Pneumonia, organism unspecified
  
  - **Unspecified ICD-10 Code**
    - I50.9 – Heart failure, unspecified
    - J18.9 – Pneumonia, unspecified organism

Questions Concerning ICD-10

If you have a question as it pertains to ICD-10, please consult with your Network Operations Representative.

Coordination of Benefits and Subrogation Guidelines

General Definitions

**Coordination of Benefits (COB):** Benefits that a person is entitled to under multiple plan coverage. Coordinating payment of these plans will provide benefit coverage up to but not exceeding one hundred (100) percent of the allowable amount. The respective primary and secondary payment obligations of the two coverages are determined by the Order of Benefits Determination Rule contained in the...
Order of Benefit Determination Rule: Rules which, when applied to a particular member covered by at least two plans, determine the order of responsibility each plan has with respect to the other plan in providing benefits for that member. A plan will be determine to have Primary or Secondary responsibility for a person’s coverage with respect to other plans by applying the NAIC rules.

Primary: This carrier is responsible for costs of services provided up to the benefit limit for the coverage or as if no other coverage exists.

Secondary: This carrier is responsible for the total allowable charges, up to the benefit limit for the coverage less the primary payment not to exceed the total amount billed (maintenance of benefits).

Allowable Expense: Any expense customary or necessary, for health care services provided as well as covered by the member’s Health Care Plan.

Conclusion: COB is applying the NAIC rules to determine which plan is primarily responsible and plan would be in a secondary position when alternate coverage exists. If COB is to accomplish its purpose, all plans must adhere to the structure set forth in the Model COB regulations.

Basic NAIC Rules for COB

Birthday Rule: The primary coverage is determined by the birthday that falls earliest in the year, understanding both spouses are employed and have coverage. Only the day and month are taken into consideration. If both members have the same date of birth, the plan which covered the member the longest is considered primary.

General Rules: The following table contains general rules to follow to determine a primary carrier.

<table>
<thead>
<tr>
<th>If The Member/Beneficiary...</th>
<th>The Below Conditions Exists</th>
<th>Then The Below Program Pays First</th>
<th>The Below Program Pays Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is age 65 or older, and is covered by a Group Health Plan (GHP) through current employment or a family members current employment</td>
<td>The employer has more than 20 employees, or at least one employer is a multi-employer group that employs 20 or more employees</td>
<td>The Group Health Plan (GHP) pays primary</td>
<td>Cigna-HealthSpring/ Medicare pays secondary</td>
</tr>
<tr>
<td>Is age 65 or older and is covered a Group Health Plan (GHP) through current employment or a family members current employment</td>
<td>The employer has less than 20 employees</td>
<td>Cigna-HealthSpring / Medicare pays primary</td>
<td>Group Health Plan (GHP) pays secondary</td>
</tr>
<tr>
<td>Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family members current employment...</td>
<td>The employer has 100 or more employees or at least one employer is a multi-employer group that employs 100 or more employees</td>
<td>The Large Group Health Plan (LGHP) pays primary</td>
<td>Cigna-HealthSpring / Medicare pays secondary</td>
</tr>
<tr>
<td>Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family members current employment...</td>
<td>The employer employs less than 100 employees</td>
<td>Cigna-HealthSpring / Medicare pays primary</td>
<td>Large Group Health Plan (LGHP) pays secondary</td>
</tr>
<tr>
<td>Is age 65 or older or entitled based on disability and has retirement insurance only</td>
<td>Does not matter the number of employees</td>
<td>Cigna-HealthSpring / Medicare pays primary</td>
<td>Retirement Insurance pays secondary</td>
</tr>
<tr>
<td>Is age 65 or older or is entitled based on disability and has COBRA coverage</td>
<td>Does not matter the number of employees</td>
<td>Cigna-HealthSpring/Medicare pays primary</td>
<td>COBRA pays secondary</td>
</tr>
<tr>
<td>If The Member/Beneficiary...</td>
<td>The Below Conditions Exists</td>
<td>Then The Below Program Pays First</td>
<td>The Below Program Pays Secondary</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Becomes dually entitled based on age/ESRD</td>
<td>Had insurance prior to becoming dually entitled with ESRD as in block one above</td>
<td>The Group Health Plan (GHP) pays primary for the first 30 months</td>
<td>Cigna-HealthSpring/Medicare pays secondary (after 30 months Cigna-HealthSpring pays primary)</td>
</tr>
<tr>
<td>Becomes dually entitled based on age/ESRD but then retires and keeps retirement insurance</td>
<td>Had insurance prior to becoming dually entitled with ESRD as in block one above and then retired</td>
<td>The Retirement Insurance pays primary for the first 30 months</td>
<td>Cigna-HealthSpring/Medicare pays secondary (after 30 months Cigna-HealthSpring pays primary)</td>
</tr>
<tr>
<td>Becomes dually entitled based on age/ESRD but then obtains COBRA insurance through employer</td>
<td>Had insurance prior to becoming dually entitled with ESRD as in block one above and picks up COBRA coverage</td>
<td>COBRA insurance would pay primary for the first 30 months (or until the member drops the COBRA coverage)</td>
<td>Cigna-HealthSpring/Medicare pays secondary (after 30 months Cigna-HealthSpring pays primary)</td>
</tr>
<tr>
<td>Becomes dually entitled based on disability/ESRD</td>
<td>Had insurance prior to becoming dually entitled with ESRD as in block three above</td>
<td>The Large Group Health Plan (LGHP) pays primary</td>
<td>Cigna-HealthSpring/Medicare pays secondary (after 30 months Cigna-HealthSpring pays primary)</td>
</tr>
<tr>
<td>Becomes dually entitled based on disability/ESRD but then obtains COBRA insurance through employer</td>
<td>Had insurance prior to becoming dually entitled with ESRD as in block three above and picks up the COBRA coverage</td>
<td>COBRA insurance would pay primary for the first 30 months or until the member drops the COBRA coverage</td>
<td>Cigna-HealthSpring/Medicare pays secondary (after 30 months Cigna-HealthSpring pays primary)</td>
</tr>
</tbody>
</table>

**Basic Processing Guidelines for COB**

For Cigna-HealthSpring to be responsible as either the primary or secondary carrier, the member must follow all HMO rules (i.e. pay co-pays and follow appropriate referral process).

When Cigna-HealthSpring is the secondary insurance carrier:

- All Cigna-HealthSpring guidelines must be met in order to reimburse the provider (i.e. pre-certification, referral forms, etc.)
- The provider collects only the co-payments required
- Be sure to have the member sign the “assignment of benefits” sections of the claim form
- Once payment and/or EOB are received from the other carriers, submit another copy of the claim with the EOB of Cigna-HealthSpring for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

When Cigna-HealthSpring is the primary insurance carrier:

- The provider collects the co-payment required under the member’s Cigna-HealthSpring plan
- Submit the claim to Cigna-HealthSpring first
- Be sure to have the member sign the “assignment of benefits” sections of the claim form
- Once payment and/or remittance advise (RA) has been received from Cigna-HealthSpring, submit a copy of the claim with the RA to the secondary carrier for adjudication

Please note that Cigna-HealthSpring is a total replacement for Medicare.

- Medicare cannot be secondary when members have Cigna-HealthSpring.
- Medicaid will not pay the co-pay for Cigna-HealthSpring members.

**Worker’s Compensation**

Cigna-HealthSpring does not cover worker’s compensation claims.

When a provider identifies medical treatment as related to an on-the-job illness or injury, Cigna-HealthSpring must be notified. The provider will bill the worker’s compensation carrier for all services rendered, not Cigna-HealthSpring.

**Subrogation**

Subrogation is the coordination of benefits between a health insurer and a third party insurer (i.e. property and casualty insurer, automobile insurer, or worker’s compensation carrier), not two health insurers.

Claims involving Subrogation or Third Party Recovery (TPR) will be processed internally by the Cigna-HealthSpring Claims Department. COB protocol, as mentioned above, would still apply in the filing of the claim.
Members who may be covered by third party liability insurance should only be charged the required co-payment. The bill can be submitted to the liability insurer. The provider should submit the claim to Cigna-HealthSpring with any information regarding the third party carrier (i.e. auto insurance name, lawyers name, etc...). All claims will be processed per the usual claims procedures.

Cigna-HealthSpring uses an outside vendor for review and investigation of all possible subrogation cases. This vendor coordinates all requests for information from the member, provider and attorneys office and assists with settlements. For claims related questions, please contact Provider Customer Service at 1-800-230-6138. A Provider Representative will gladly provide assistance.

Appeals
You may appeal a previous decision not pay for a service, including a decision to pay for a different level of care; this includes not just outright denials, but also “partial” ones. Examples of partial denials include denials of certain levels of care, line items on a claim, or a decreased number of office or therapy visits. Partial denials of payment may be appealed using the same processes as appeals of full denials. Your appeal will receive an independent review (made by someone not involved in the initial decision) at Cigna-HealthSpring. Requesting an appeal does not guarantee that your request will be approved or your claim paid. The appeal decision may still be to fully or partially uphold the original decision. You have one level of appeal, so that decision is final.

You may appeal, on behalf of a member, a health services/UM denial of a service not yet provided. The member will need to be advised that you are appealing on his or her behalf. Member appeals are processed according to Medicare rules.

An appeal must be submitted to the address/fax listed below within 60 days from the original decision. You must include with your appeal request a copy of your denial, any medical records that would support why the service is needed, and if for a hospital stay or office visit, a copy of the insurance verification done on the date of service or admission.

Appeals can take up to 60 days to be processed. The time frame in which a claim must be filed to be considered timely is not impacted or affected or changed by the appeal process or the appeal outcome. If the appeal decision results in approval of payment that is contingent on the filing of a corrected claim, the time frame is not automatically extended and remains consistent with the timely filing provision in the Cigna-HealthSpring Agreement.

An Appeal is the request for Cigna-HealthSpring to review a previously made decision. You must receive a Notice of Denial of Medical Non-Coverage or Remittance Advice before you can submit an appeal. Please do not send initial claims as appeals.

**Part C Appeals Addresses and Fax Numbers**

<table>
<thead>
<tr>
<th>State</th>
<th>Address</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>Cigna-HealthSpring Attn: Appeals Unit PO Box 24087 Nashville, TN 37202-4087</td>
<td>1-800-511-6943</td>
</tr>
<tr>
<td></td>
<td>Fax #</td>
<td>1-800-931-0149</td>
</tr>
</tbody>
</table>

**HEALTHCARE PLAN EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)**

HEDIS (a standardized data set) is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters) and medical record review data. HEDIS measurements include measures such as Comprehensive Diabetes Care, Adult Access to Ambulatory and Preventive Care, Glaucoma Screening for Older Adults, Controlling High Blood Pressure, Breast Cancer Screening, and Colorectal Cancer Screening.

Plan-wide HEDIS measures are reported annually and represent a mandated activity for Health Plans contracting with the Centers for Medicare and Medicaid Services (CMS). Each spring, Cigna-HealthSpring Representatives will be required to collect from practitioner offices copies of medical records to establish HEDIS scores. Selected practitioner offices will be contacted and requested to assist in these medical record collections.

All records are handled in accordance with Cigna-HealthSpring’s privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS initiative, will be requested. HEDIS is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506].

Cigna-HealthSpring’s HEDIS results are available upon request. Contact the Health Plan’s Quality Improvement Department to request information regarding those results.

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

The Center for Medicare and Medicaid Services (CMS) uses the Five-Star Quality Rating System to determine how much to compensate Medicare Advantage plans and educate consumers on health plan quality. The Star Ratings system consists of over 50 measures from five different rating systems. The cumulative results of these measures make up the Star rating assigned to each health plan.

Star Ratings have a significant impact on the financial outcome of Medicare Advantage health plans by directly influencing the bonus payments and rebate percentages received. CMS will award quality-based bonus payments to high performing health plans based on their Star Ratings performance. For health plans with a four star or more rating, a bonus payment is paid in the form of a percentage (maximum of five percent) added to the county benchmark. [A county benchmark is the amount CMS expects it to cost to provide hospital and medical insurance in the state and county.] After 2015, any health plans with Star Ratings below four will no longer receive bonus payments.

**Star Rating Components**

The Star Rating is comprised of over 50 different measures from six different rating systems:

**Star Rating System:**

- HEDIS-The Healthcare Effectiveness Data and Information Set is a set of performance measures developed for the managed care industry. All claims are processed regularly to extract the NCQA (National Committee for Quality Assurance) defined measures. For example, this allows the health plan and CMS to determine how many enrollees have been screened for high blood pressure.

- CAHPS- Consumer Assessment of Healthcare Providers and Systems is a series of patient surveys rating healthcare experiences that is performed on behalf of CMS by an approved vendor.

- CMS- Center for Medicare and Medicaid services rates each plan on administrative type metrics, such as, beneficiary access, complaints, call center hold times and percentage of members choosing to leave a plan.

- PDE- Prescription Drug Events is data collected on various medications related events, such as, high-risk medications, adherence for chronic conditions and pricing.

- HOS- Health Outcomes Survey is a survey that uses patient-reported outcomes over a 2.5-year time span to measure health plan performance. Each spring a random sample of Medicare beneficiaries is drawn from each participating Medicare Advantage Organization (MAO) that has a minimum of 500 enrollees and is surveyed. Two years later, these same respondents are surveyed again (i.e., follow up measurement).

- IRE- Medicare Advantage plans are required to submit all denied enrollee appeals (Reconsiderations) to an Independent Review Entity (MAXIMUS Federal Services).

**These systems rate the plans based on five domains:**

1. Staying Healthy: Screenings, Tests and Vaccines
2. Managing Chronic (Long Term) Conditions
3. Member Experience with Health Plan
4. Member Complaints, Problems Getting Services, and Improvement in the Health Plan’s Performance
5. Health Plan Customer Service
6. Data used to calculate the ratings comes from surveys, observation, claims data and medical records.

CMS continues to evolve the Star ratings system by adding, removing and adjusting various measures on a yearly basis. CMS weights each measure between one and three points. A three point measure, or triple weighted measure, are those measures that CMS finds most important and should be a focus for health plans. The composition of all rating systems is indicated below.

**Health Reform**

The Patient Protection and Affordable Care Act (PPACA) requires that Medicare Advantage plans be awarded quality-based bonus payments beginning in 2012, as measured by the Star ratings system. Bonus payments are provided to MA plans that receive four or more stars. CMS assigns a benchmark amount to each county within a state, which is the maximum amount CMS will pay to provide hospital and medical benefits. All MA plans submit a bid, which is the projected cost to operate MA within the county. The spread between the bid and original benchmark is called the rebate. A bonus payment is the percentage added to the county benchmark, which increases the spread and the amount of revenue received by the health plan.

<table>
<thead>
<tr>
<th>Plan Quality Score</th>
<th>2012-13</th>
<th>2014</th>
<th>2015 and after</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 stars</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>3 stars</td>
<td>3.0%</td>
<td>3.0%</td>
<td>—</td>
</tr>
<tr>
<td>3.5 stars</td>
<td>3.5%</td>
<td>3.5%</td>
<td>—</td>
</tr>
<tr>
<td>4 stars</td>
<td>4.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>4.5 stars</td>
<td>4.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>5 stars</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>
Star Measure Weighting

Individual Star measures can be single-weighted, 1.5-weighted or triple-weighted, with higher weight being given to those measures that CMS deems most important by which to measure plan quality. Triple-weighted measures are typically outcomes measures that measure a health plan’s ability to manage chronic illnesses and keep members healthy. Certain disease states appear in multiple measures. For example, diabetes directly impacts 7 measures and cardiovascular conditions directly impact 4 measures.

Following is a summary of the weighting of all Star measures:

<table>
<thead>
<tr>
<th>Part C Star Rating Measure</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening (HEDIS)</td>
<td>1</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (HEDIS)</td>
<td>1</td>
</tr>
<tr>
<td>Cardio Care - LDL Screen (HEDIS)</td>
<td>1</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - LDL Screen (HEDIS)</td>
<td>1</td>
</tr>
<tr>
<td>Glaucoma Testing (HEDIS)</td>
<td>1</td>
</tr>
<tr>
<td>Annual Flu Vaccine (CAHPS)</td>
<td>1</td>
</tr>
<tr>
<td>Improving/Maintaining Physical Health (HOS)</td>
<td>3</td>
</tr>
<tr>
<td>Monitoring Physical Activity (HOS)</td>
<td>1</td>
</tr>
<tr>
<td>Adult BMI Assessment (HEDIS)</td>
<td>1</td>
</tr>
<tr>
<td>Care For Older Adults - Medication Review (HEDIS)</td>
<td>1</td>
</tr>
<tr>
<td>Care For Older Adults - Pain Screening (HEDIS)</td>
<td>1</td>
</tr>
<tr>
<td>Osteoporosis Fracture Management (HEDIS)</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part D Star Rating Measure</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign language Interpreter and TTY/TDD Availability (Call Center)</td>
<td>1.5</td>
</tr>
<tr>
<td>Appeals Autoforward (IRE)</td>
<td>1.5</td>
</tr>
<tr>
<td>Appeals Upheld (IRE)</td>
<td>1.5</td>
</tr>
<tr>
<td>Complaints About The Health Plan (CTM)</td>
<td>1.5</td>
</tr>
<tr>
<td>Beneficiary Access And Performance Problems (CMS)</td>
<td>1.5</td>
</tr>
<tr>
<td>Members Choosing To Leave The Plan (CMS)</td>
<td>1.5</td>
</tr>
<tr>
<td>Improvement (CMS)</td>
<td>3</td>
</tr>
<tr>
<td>Rating Of Drug Plan CAHPS</td>
<td>1.5</td>
</tr>
<tr>
<td>Getting Needed Prescription Drugs (CAHPS)</td>
<td>1.5</td>
</tr>
<tr>
<td>MPF Pricing Accuracy (PDE)</td>
<td>1</td>
</tr>
<tr>
<td>High Risk Medications (PDE)</td>
<td>3</td>
</tr>
<tr>
<td>Diabetes Treatment (PDE)</td>
<td>3</td>
</tr>
<tr>
<td>Medication Adherence For Oral Diabetes Medications (PDE)</td>
<td>3</td>
</tr>
<tr>
<td>Medication Adherence For Hypertension (PDE)</td>
<td>3</td>
</tr>
<tr>
<td>Medication Adherence For Cholesterol (PDE)</td>
<td>3</td>
</tr>
</tbody>
</table>

Star Rating Timeline

The Star rating process follows a unique lag timeline that must be iterated. Each year, CMS publishes Health Plan ratings in October which encompass data collected in the previous year. After ratings are determined, bonuses payments can be included in the bid process for the following year. This means that actions taken to affect Stars in a given year take almost three years to realize financially. For example:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
BEHAVIORAL HEALTH

Cigna-HealthSpring provides comprehensive mental health and substance abuse services to its members. Its goal is to treat the member in the most appropriate, least restrictive level of care possible, and to maintain and/or increase functionality.

Cigna-HealthSpring’s network is comprised of mental health and substance abuse services and providers who identify and treat members with behavioral health care needs.

Integration and communication among behavioral health and physical health providers is most important. Cigna-HealthSpring encourages and facilitates the exchange of information between and among physical and behavioral health providers. Member follow-up is essential. High risk members are evaluated and encouraged to participate in Cigna-HealthSpring’s behavioral health focused Case Management Program where education, care coordination, and support is provided to increase member’s knowledge and encourage compliance with treatment and medications. Cigna-HealthSpring works with its providers to become part of the strategy and the solution to provide quality behavioral health services.

Behavioral Health Services: Behavioral Health services are available and provided for the early detection, prevention, treatment, and maintenance of the member’s behavioral health care needs. Behavioral health services are interdisciplinary and multidisciplinary: a member may need one or multiple types of behavioral health providers, and the exchange of information among these providers is essential. Mental health and substance abuse benefits cover the continuum of care from the least restrictive outpatient levels of care to the most restrictive inpatient levels of care.

Behavioral Health services include:

• Access to Cigna-HealthSpring’s Customer Service for orientation and guidance
• Routine outpatient services to include psychiatrist, addictionologist, licensed psychologist and LCSWs, and psychiatric nurse practitioners. PCPs may provide behavioral health services within his/her scope of practice
• Initial evaluation and assessment
• Individual and group therapy
• Psychological testing according to established guidelines and needs
• In-patient hospitalization
• Inpatient and out-patient detoxification treatment
• Medication management
• Partial hospitalization programs

Responsibilities of Behavioral Health Providers:
Cigna-HealthSpring encourages behavioral health providers to become part of its network. Their responsibilities include but are not limited to:

• Provide treatment in accordance with accepted standards of care
• Provide treatment in the least restrictive level of care possible
• Communicate on a regular basis with other medical and behavioral health practitioners who are treating or need to treat the member
• Direct members to community resources as needed to maintain or increase member’s functionality and ability to remain in the community

Responsibilities of the Primary Care Physician:
The PCP can participate in the identification and treatment of their member’s behavioral health needs. His/her responsibilities include:

• Screening and early identification of mental health and substance abuse issues
• Treating members with behavioral health care needs within the scope of his/her practice and according to established clinical guidelines. These can be members with co-morbid physical and minor behavioral health problems or those members refusing to access a mental health or substance abuse provider, but requiring treatment
• Consultation and/or referral of complex behavioral health patients or those not responding to treatment
• Communication with other physical and behavioral health providers on a regular basis

Access to Care
Members may access behavioral health services as needed:

• Members may self refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.
• Members may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCP’s scope of practice. They may request a referral to a behavioral health practitioner. Referrals however, are not required to receive most in-network mental health or substance abuse services
• Members and providers can call Cigna-HealthSpring Behavioral Health Customer Service to receive orientation on how to access behavioral health services, provider information, and prior authorizations at 1-866-780-8546.
Medical Record documentation

When requesting prior authorization for specific services or billing for services provided, behavioral health providers must use the DSM-IV multi-axial classification system and document a complete diagnosis. The provision of behavioral health services require progress note documentation that correspond with day of treatment, the development of a treatment plan, and discharge plan as applicable for each member in treatment.

Continuity of Care

Continuity of Care is essential to maintain member stability. Behavioral health practitioners and PCPs, as applicable, are required to:

- Evaluate member if he/she was hospitalized for a behavioral health condition within 7 days post-discharge
- Provide members receiving care with contact information for any emergency or urgent matter arising that necessitates communication between the member and the provider
- Evaluate member needs when the member is in acute distress
- Communicate with the member’s other healthcare providers
- Identify those members necessitating follow-up and refer to Cigna-HealthSpring’s behavioral health focused Case Management Program as necessary
- Discuss cases as needed with a peer reviewer
- Make request to Cigna-HealthSpring for authorization for member in an active course of treatment with a non-participating practitioner

Utilization Management

Cigna-HealthSpring’s Health Services Department coordinates behavioral health care services to ensure appropriate utilization of mental health and substance abuse treatment resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically-appropriate, and cost-effective manner for the members.

Cigna-HealthSpring Utilization Management staff base their utilization-related decisions on the clinical needs of members, the member’s Benefit Plan, Interqual Criteria, Milliman Guidelines, the appropriateness of care, Medicare National Coverage Guidelines, health care objectives, and scientifically-based clinical criteria and treatment guidelines in the context of provider and/or member-supplied clinical information and other relevant information.

Health Services

Cigna-HealthSpring’s Health Services Department coordinates health care services to ensure appropriate utilization of health care resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically-appropriate, and cost-effective manner for the members.

Cigna-HealthSpring Utilization Management staff base their utilization-related decisions on the clinical needs of members, the member’s Benefit Plan, Interqual Criteria, Milliman Guidelines, the appropriateness of care, Medicare National Coverage Guidelines, health care objectives, and scientifically-based clinical criteria and treatment guidelines in the context of provider and/or member-supplied clinical information and other relevant information.

Goals

- To ensure that services are authorized at the appropriate level of care and are covered under the member’s health plan benefits;
- To monitor utilization practice patterns of Cigna-HealthSpring’s contracting physicians, contracting hospitals, contracting ancillary services, and contracting specialty providers;
- To provide a system to identify high-risk members and ensuring that appropriate care is accessed;
- To provide utilization management data for use in the process of re-credentialing providers;
- To educate members, physicians, contracted hospitals, ancillary services, and specialty providers about Cigna-HealthSpring’s goals for providing quality, value-enhanced managed health care; and
- To improve utilization of Cigna-HealthSpring’s resources by identifying patterns of over- and under-utilization that have opportunities for improvement.

Departmental Functions

- Prior Authorization
- Referral Management
- Concurrent Review
- Discharge Planning
- Case Management and Disease Management
- Continuity of Care
Prior Authorization

The Primary Care Physician (PCP) or Specialist is responsible for requesting prior authorization of all scheduled admissions or services/procedures, for referring a member for an elective admission, outpatient service, and for requesting services in the home. Cigna-HealthSpring recommends calling at least five (5) days in advance of the admission, procedure, or service. Requests for prior authorization are prioritized according to level of medical necessity. For prior authorizations, providers should call 1-800-511-6932. You may also submit your request via our online portal 24 hours per day, 7 days per week at: https://HealthSpring.hsconnectonline.com/HSConnect

Services requiring prior authorization are listed in the appendix section of this manual, as well as on Cigna-HealthSpring’s website. The presence or absence of a service or procedure on the list does not determine coverage or benefits. Call Customer Service to verify benefits, coverage, and member eligibility.

The Prior Authorization Department, under the direction of licensed nurses and medical directors, documents and evaluates requests for authorization, including:

- Verification that the member is enrolled with Cigna-HealthSpring at the time of the request for authorization and on each date of service.
- Verification that the requested service is a covered benefit under the member’s benefit package.
- Determination of the appropriateness of the services (medical necessity).
- Verification that the service is being provided by the appropriate provider and in the appropriate setting.
- Verification of other insurance for coordination of benefits.

The Prior Authorization Department documents and evaluates requests utilizing CMS guidelines as well as nationally accepted criteria, processes the authorization determination, and notifies the provider of the determination.

Examples of information required for a determination include, but are not limited to:

- Member name and identification number
- Location of service (e.g., hospital or surgi-center setting)
- Primary Care Physician name
- Servicing/Attending physician name
- Date of service
- Diagnosis
- Service/Procedure/Surgery description and CPT or HCPCS code
- Clinical information supporting the need for the service to be rendered

For members who go to an emergency room for treatment, an attempt should be made in advance to contact the PCP unless it is not medically feasible due to a serious condition that warrants immediate treatment.

If a member appears at an emergency room for care which is non-emergent, the PCP should be contacted for direction. The member may be financially responsible for payment if the care rendered is non-emergent. Cigna-HealthSpring also utilizes urgent care facilities to treat conditions that are non-emergent but require immediate treatment.

Emergency admissions must be precertified by Cigna-HealthSpring within twenty-four (24) hours, or the next business day, of admission. Please be prepared to discuss the member’s condition and treatment plan with our nurse coordinator.

Outpatient Prior Authorization Department

Triage Unit:

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

Prior Authorization Unit:

- Consists of RN’s and LPN’s
- Teams of nurses are organized based on member’s PCP or provider specialty
- Handles all issues that require a clinical determination, such as:
  - Infusion
  - Outpatient Surgical Procedures
  - DME / O&P
  - Ambulance transports
  - Outpatient Diagnostic Testing
  - Outpatient Therapy
ICD-10 Diagnosis and Procedure Code Reporting Begins October 1, 2014

In January 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the use of International Classification of Diseases version 10 (ICD-10) for diagnosis and hospital inpatient procedure coding. The rule impacts the health care industry – including health plans, hospitals, doctors and other health care professionals, as well as vendors and trading partners.

ICD-10 (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

- ICD-10-CM for Diagnosis coding is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 characters instead of the 3 to 5 characters used with ICD-9-CM, adding more specificity.

- ICD-10-PCS for Inpatient Procedure coding is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric characters instead of the 3 or 4 numeric characters used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

Note: Procedure codes are only applicable to claims and not prior authorizations.

The transition to ICD-10 is occurring because ICD-9 codes have limited data about patients’ medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT coding for outpatient procedures.

ICD-9 vs. ICD-10 Prior Authorization Guidelines

Health care professionals must be prepared to comply with the transition to ICD-10 by October 1, 2014. Cigna-HealthSpring will strictly adhere to the following guidelines:

- Prior authorizations for services requested prior to October 1, 2014 must be submitted with ICD-9 diagnosis codes.
- Prior authorizations for services requested on or after October 1, 2014 must be submitted with ICD-10 diagnosis codes.
- If a prior authorization crosses the October 1, 2014 compliance date, we will accept services with ICD-9 codes if the prior authorization was requested prior to October 1, 2014. Two separate authorizations, one before October 1, 2014 and one on or after October 1, 2014 will not be required.
- Prior authorizations with ICD-10 diagnosis codes cannot be accepted until on or after October 1, 2014.

Billable vs. Non-billable Codes

A billable ICD-9 or ICD-10 code is defined as a code that has been coded to its highest level of specificity.

<table>
<thead>
<tr>
<th>Billable ICD-9 Codes</th>
<th>Non-billable ICD-9 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>473.0 - Chronic maxillary sinusitis</td>
<td>473 - Chronic sinusitis</td>
</tr>
<tr>
<td>474.00 - Chronic tonsillitis</td>
<td>474 - Chronic disease of tonsils and adenoids</td>
</tr>
</tbody>
</table>

A non-billable ICD-9 or ICD-10 code is defined as a code that has not been coded to its highest level of specificity. Cigna-HealthSpring cannot process a prior authorization with a non-billable code.

<table>
<thead>
<tr>
<th>Billable ICD-10 Codes</th>
<th>Non-billable ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1A3110 - Chronic gout due to renal impairment, right shoulder, without tophus</td>
<td>M1A3 - Chronic gout due to renal impairment</td>
</tr>
<tr>
<td>474 - Chronic disease of tonsils and adenoids</td>
<td>M1A311 - Chronic gout due to renal impairment, right shoulder</td>
</tr>
</tbody>
</table>

The following are examples of billable ICD-9 codes with corresponding non-billable codes:

<table>
<thead>
<tr>
<th>Billable ICD-9 Codes</th>
<th>Non-billable ICD-9 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>428 - Congestive heart failure, unspecified</td>
<td>150.9 - Heart Failure, unspecified</td>
</tr>
<tr>
<td>486 - Pneumonia, organism unspecified</td>
<td>J18.9 - Pneumonia, unspecified organism</td>
</tr>
</tbody>
</table>

Decisions and Time Frames

Emergency - Authorization is not required

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of
health and medicine, could reasonably expect the absence of immediate medical attention to result in:

• Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
• Serious impairment to bodily functions; or
• Serious dysfunction of any bodily organ or part

Expedited

An expedited request can be requested when you as a physician believe that waiting for a decision under the routine time frame could place the member’s life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined within 72 hours or as soon as the member’s health requires.

Routine

If all information is submitted at the time of the request, CMS mandates a healthplan determination within 14 calendar days.

Once the Precertification Department receives the request for authorization we will review the request using nationally recognized industry standards or local coverage determination criteria. If the request for authorization is approved, Cigna-HealthSpring will assign an authorization number and enter the information in our medical management system. This authorization number can be used to reference the admission, service or procedure.

The requesting provider has the responsibility of notifying the member that services are approved and documenting the communication in the medical record.

Retrospective Review

Retrospective review is the process of determining coverage for clinical services by applying guidelines/criteria to support the claim adjudication process after the opportunity for precertification or concurrent review timeframe has passed. The only scenarios in which retrospective requests can be accepted are:

• Authorizations for claims billed to an incorrect carrier
  - As long as you have not billed the claim to Cigna-HealthSpring and received a denial, you can request a retro authorization from Health Services within 2 business days of receiving the RA from the incorrect carrier.
  - If the claim has already been submitted to Cigna-HealthSpring and you have received a denial, the request for retro authorization then becomes an appeal and you must follow the guidelines for submitting an appeal.
• Services / Admissions after hours, weekends, or holidays
  - Cigna-HealthSpring will retrospectively review any medically necessary services provided to Cigna-HealthSpring Members after hours, holidays, or weekends. Cigna-HealthSpring does require the retro authorization request and applicable clinical information to be submitted to the Health Services dept. within 2 business days of providing the service or admitting the Member.
  - In accordance with Cigna-HealthSpring policy, retrospective requests for authorizations not meeting the scenarios listed above may not be accepted and these claims may be denied for payment.
  - After confirming the member’s eligibility and the availability of benefits at the time the service was rendered, providers should submit all supporting clinical documentation with the request for review and subsequent reimbursement via fax to 1-832-553-3426. Please refer to the Prior Authorization Grid on page 50 based on your specific service for authorization guidelines and/or requirements.
  - The requesting provider has the responsibility of notifying the member that services are approved and documenting the communication in the medical record.

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital admission, rehabilitation admission or skilled nursing facility or other inpatient admission in order to ensure:

• Covered services are being provided at the appropriate level of care; and
• Services are being administered according to the individual facility contract.

Cigna-HealthSpring requires admission notification for the following:

• Elective Admissions
• ER and Urgent Admissions
• Transfers to Acute Rehabilitation, LTAC and SNF Admissions
• Admissions following outpatient procedures or observation status
A Cigna-HealthSpring Medical Director reviews all acute, rehab, LTAC and SNF confinements that do not meet medical necessity criteria and issues a determination. If the Cigna-HealthSpring Medical Director deems that the inpatient or SNF confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The Concurrent Review nurse or designee will notify the provider(s) e.g. facility, attending/ordering provider verbally and in writing of the adverse determination via Notice of (Inpatient) Denial of Medicare Coverage (NDMC). The criteria used for the determination is available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made, 1-800-511-6932.

In those instances where the Attending provider does not agree with the determination, the provider is encouraged to contact Cigna-HealthSpring’s Medical Director for Peer-to-Peer discussion. The telephone number to contact our Medical Director for the discussion call 1-800-511-6932. Following the Peer-to-Peer discussion, the Medical Director will either reverse the original determination and authorize the confinement or uphold the adverse determination.

For members receiving hospital care and for those who transfer to a Skilled Nursing Facility or Acute Inpatient Rehabilitation Care, Cigna-HealthSpring will approve the request or issue a Notice of Denial of Medical Coverage (NDMC) if the request is not medically necessary. Cigna-HealthSpring will also issue a NDMC if a member who is already receiving care in an Acute Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of care. This document will include information on the members’ or their Representatives’ right to file an expedited appeal, as well as instructions on how to do so if the member or member’s physician does not believe the denial is appropriate.

Cigna-HealthSpring issues written Notice of Medicare Non-Coverage (NOMNC) determinations in accordance with CMS guidelines. This notice will be sent by fax to the SNF or HHA. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the member, authorized representative or POA sign the notice within the written time frame listed in the Adverse Determination section of the provider manual. The facility is requested and expected to fax a copy of the signed NOMNC back to Health Services at the number provided. The NOMNC includes information on members’ rights to file a fast track appeal.

Readmission
The Health Services Department will review all readmissions occurring within 31 days following
discharge from the same facility, according to established processes, to assure services are medically reasonable and necessary, with the goal of high quality cost effective health care services for Health Plan members.

The Health Services Utilization Management (UM) staff will review acute Inpatient and Observation readmissions. If admissions are determined to be related; they may follow the established processes to combine the two confinements.

The Role of the Cigna-HealthSpring ACCM (Acute Care Case Manager)

Cigna-HealthSpring Acute Care Case Managers (ACCMs) are registered nurses. All ACCMs are expected to perform at the height of their license. They understand Cigna-HealthSpring plan benefits and utilize good clinical judgment to ensure the best outcome for the member.

The Cigna-HealthSpring Acute Care Case Manager has two major functions:

• Ensure the member is at the appropriate level of care, in the appropriate setting, at the appropriate time through utilization review
• Effectively manage care transitions and length of stay (LOS)

Utilization review is performed utilizing evidence-based guidelines (Interqual) and collaborating with Primary Care Physicians (PCP), attending physicians and Cigna-HealthSpring medical directors.

The ACCM effectively manages all transitions of care through accurate discharge planning and collaboration with facility personnel to prevent unplanned transitions and readmissions via interventions such as:

• Medication Reconciliation
• Referral of members to Cigna-HealthSpring programs such as: CHF CCIP Program, Respiratory Care Program and Fragile Fracture Program
• Appropriate coordination of member benefits
• Obtaining needed authorizations for post-acute care services or medications
• Collaborating with attending physician and PCP, as needed
• Introducing and initiating CTI (Care Transition Intervention)
• Addressing STAR measures, as applicable:
  - Hgb A1C & foot care
  - LDL
  - Colorectal cancer screening
  - Osteoporosis management in women who had a fracture
  - Falls
  - Emotional health
  - Flu and pneumonia vaccines
  - Medication adherence

• Facilitating communication of care level changes to all parties
• The goals of the Cigna-HealthSpring ACCM are aligned with the goals of acute care facilities:
  - Members/Patients receive the appropriate care, at the appropriate time, and in the most appropriate setting
  - Readmissions are reduced and LOS is managed effectively

At Cigna-HealthSpring, we strive for Primary Care Physicians (PCP), attending physicians, and acute care facility personnel to view the Cigna-HealthSpring ACCM as a trusted resource and partner in the care of our members (your patients).

Discharge Planning/Acute Care Management

Discharge Planning is a critical component of the process that begins with an early assessment of the member’s potential discharge care needs in order to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the member and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. Cigna-HealthSpring’s Concurrent Review staff will coordinate with the facility discharge planning team to assist in establishing a safe and effective discharge plan. The Acute Care Managers (ACM) Concurrent Review nurse will facilitate the communication for all needed authorizations for services, equipment and skilled services upon discharge.

In designated contracted facilities, Cigna-HealthSpring also employs ACMs to assist with the process, review the inpatient medical record and complete face-to-face member interviews to identify members at risk for readmission, in need of post-discharge complex care coordination and to aid the transition of care process. This process is completed in collaboration with the facility discharge planning and acute care management team members and other Cigna-HealthSpring staff. When permissible by facility agreement, the ACM also completes the concurrent review process onsite at assigned hospitals. The role of the ACM onsite reviewer then also includes the day to day functions of the concurrent review process at the assigned hospital by conducting timely and consistent reviews and discussing with a Cigna-HealthSpring medical director as appropriate. The reviewer monitors the utilization of inpatient member confinement at the assigned hospitals
by gathering clinical information in accordance with hospital rules and contracting requirements including timelines for decision making. All clinical information is evaluated utilizing a nationally accepted review criteria.

The ACM onsite reviewer will identify discharge planning needs and be proactively involved by interacting with attending physicians and hospital case managers in an effort to facilitate appropriate and timely discharge. The onsite reviewer will follow the policies and procedures consistent with the guidelines set forth by Cigna-HealthSpring Services Department and the facility.

**Adverse Determinations**

**Rendering of Adverse Determinations (Denials)**

The Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits or eligibility.

Every effort is made to obtain all necessary information, including pertinent clinical information from the treating provider to allow the Medical Director to make appropriate determinations.

Only a Cigna-HealthSpring Medical Director may render an adverse determination (denial) based on medical necessity but he/she may also make a decision based on administrative guidelines. The Medical Director, in making the initial decision, may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, Cigna-HealthSpring notifies the facility or provider’s office of the denial of service. Such notice is issued to the provider and the member, when applicable, documenting the original request that was denied and the alternative approved service, along with the process for appeal.

Cigna-HealthSpring employees are not compensated for denial of services. The PCP or Attending Physician may contact the Medical Director by telephone to discuss adverse determinations.

**Notification of Adverse Determinations (Denials)**

The reason for each denial, including the specific utilization review criteria with pertinent subset/information or benefits provision used in the determination of the denial, is included in the written notification and sent to the provider and/or member as applicable. Written notifications are sent in accordance with CMS and NCQA requirements to the provider and/or member as follows:

- For non-urgent pre-service decisions – within 14 calendar days of the request.
- For urgent pre-service decisions - *within 72 hours or three calendar days of the request
- For urgent concurrent decisions - *within 24 hours of the request
- For post-service decisions – within 30 calendar days of the request

*Denotes initial oral notification of the denial decision is provided with electronic or written notification given no later than 3 calendar days after the oral notification

**Peer-to-Peer information is provided.**

Cigna-HealthSpring complies with CMS requirements for written notifications to members, including rights to appeal and grievances. For urgent care requests, Cigna-HealthSpring notifies the provider(s) only of the decision since the treating or attending practitioner is acting as the member’s representative. If the denial is either concurrent or post service (retrospective) and the member is not at financial risk, the member is not routinely notified.

**Clinical Practice Guidelines & Reference Material**

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

- Define clear goals of care based on the best available scientific evidence;
- Reduce variation in care and outcomes;
- Provide a more rational basis for clinical management of some conditions;
- Comply with accreditation standards and regulatory expectations.
- The table on 110 contains the clinical practice guidelines approved by Cigna-HealthSpring’s Clinical Policy Committee. The table also contains links to the Web sites with the most current version of the guideline.

This information is provided for general reference and not intended to address every clinical situation associated with the conditions and diseases addressed by these guidelines. Physicians and health care professionals must exercise clinical discretion in interpreting and applying this information to individual patients. We hope you will consider this information and use it, when it is appropriate for your eligible members.

**REFERRAL PROCESS**

The Primary Care Physician (PCP) is the member’s primary point of entry into the health care delivery system for all outpatient specialist care.
The PCP is required to obtain a referral for most outpatient specialist visits for Cigna-HealthSpring members.

Referrals can be requested through several methods, such as:

- IVR
- Fax
- Phone
- HS Connect

Your Network Operations representative can provide additional details regarding preferred method of communication in your area. Likewise, the specialist is required to ensure that a referral is in place prior to scheduling a visit (except urgent/emergent visits, which do not require referral). The specialist is also required to communicate to the PCP via consultation reports any significant findings, recommendations for treatment and the need for any ongoing care.

Electronic submission/retrieval of referrals through HSConnect helps to ensure accurate and timely processing of referrals.

**Referral Guidelines**

- PCPs should refer only to Cigna-HealthSpring participating specialists for outpatient visits.
- Non-participating specialist’s visits require prior authorization by Cigna-HealthSpring
- Referrals must be obtained PRIOR to specialist services being rendered
- PCPs should not issue retroactive referrals
- Most referrals are valid for 180 days starting from the issue date
- All requests for referrals must include the following information:
  - Member Name, Date of Birth, Member ID
  - PCP Name
  - Specialist Name
  - Date of Referral
  - Number of visits requested

If a member is in an active course of treatment with a specialist at the time of enrollment, Cigna-HealthSpring will evaluate requests for continuity of care. A PCP referral is not required, but an authorization must be obtained from Cigna-HealthSpring’s Prior Authorization Department. For further details, please refer to the Continuity of Care section in Health Services.

**Self Referrals**

Members have open access to certain specialists, known as self-referred visits/services; these include but are not limited to:

- Emergency medicine (emergency care as defined in the provider contract)
- Obstetric and Gynecological care (routine care, family planning)
- Psychiatrist, Psychologist, Licensed Clinical Social Worker (behavioral health participating providers)

**CASE MANAGEMENT SERVICES**

The Cigna-HealthSpring Management Program is an administrative and clinically proactive process that focuses on coordination of services for members with multiple comorbidities, complex care needs and/or short term requirements for care. The Program is designed to work as a partnership between members, providers, and other health services staff. The goal is to provide the best clinical outcomes for members. The central concept is early identification, education, and measurement of compliance with standards of care. The case management staff strives to enhance the member’s quality of life, facilitates provision of services in the appropriate setting, and promotes quality cost effective outcomes. Staff members with specific clinical expertise provide support services and coordination of care in conjunction with the treating provider.

**Case Management Program Goals**

Cigna-HealthSpring has published and actively maintains a detailed set of Program objectives available upon request in our case management program description. These objectives are clearly stated, measurable, and have associated internal and external benchmarks against which progress is assessed and evaluated throughout the year. Plan demographic and epidemiologic data, and survey data are used to select Program objectives, activities, and evaluations.

**Case Management Approach**

Cigna-HealthSpring has multiple programs in place to promote continuity and coordination of care, remove barriers to care, prevent complications and improve member quality of life. It is important to note that Cigna-HealthSpring treats disease management as a component of the case management continuum, as opposed to a separate and distinct activity. In so doing, we are able to seamlessly manage cases across the care continuum using integrated staffing, content, data resources, risk identification algorithms, and computer applications.

Cigna-HealthSpring employs a segmented and individualized case management approach that
focuses on identifying, prioritizing, and triaging cases effectively and efficiently. Our aim is to assess the needs of individual members, to secure their agreement to participate, and to match the scope and intensity of our services to their needs. Results from health risk assessment surveys, eligibility data, retrospective claims data, and diagnostic values are combined using proprietary rules, and used to identify and stratify members for case management intervention. The plan uses a streamlined operational approach to identify and prioritize member outreach, and focuses on working closely with members and family/caregivers to close key gaps in education, self-management, and available resources. Personalized case management is combined with medical necessity review, ongoing delivery of care monitoring, and continuous quality improvement activities to manage target member groups.

Members are discharged from active case management under specific circumstances which may include stabilization of symptoms or a plateau in disease processes, the completed course of therapy, member specific goals obtained; or the member has been referred to Hospice. A member’s case may be re-initiated based on the identification of a transition in care, a change in risk score, or through a referral to case management.

**How To Use Services**

Members that may benefit from case identified from multiple areas including utilization management activities, predictive modeling, and direct referrals from a provider. If you would like to refer a Cigna-HealthSpring member for Case Management services, please call 1-888-501-1116. In addition, our members have access to information regarding the program via a brochure and website and may self refer. Members are contacted by our case management staff by telephone or face to face encounter. The member has the right to opt out of the program. If the member opts in, a letter will be sent to the member and you as the provider. Once enrolled, an assessment is completed with the member and a plan of care monitoring, and continuous quality improvement activities to manage target member groups.

Members are discharged from active case management under specific circumstances which may include stabilization of symptoms or a plateau in disease processes, the completed course of therapy, member specific goals obtained; or the member has been referred to Hospice. A member’s case may be re-initiated based on the identification of a transition in care, a change in risk score, or through a referral to case management.

**Coordination with Network Providers**

Cigna-HealthSpring offers members access to a contracted network of facilities, primary care and specialty care physicians, behavioral health, mental health, and alcohol and substance abuse specialists, as well as ancillary care network. Each member receives a provider directory annually giving in-depth information about how to find network providers in their area (by zip code and by specialty), how to select a PCP, conditions under which out-of-area and out-of-network providers may be seen, and procedures for when the member’s provider leaves the network. A toll-free Customer Service telephone number is provided, and members with questions are asked to reach out to the plan. Members also have access to a series of web-based provider materials. The website allows members to search the provider directory for doctors, facilities, and pharmacies.

The provider is a key member of the Interdisciplinary care team. Our case management staff will work with you and your staff to meet the unique needs of each member. Case managers work with members and providers to schedule and prepare for member visits, to make sure that identified care gaps are addressed and prescriptions are filled, and to mitigate any non-clinical barriers to care. In cases where provider referrals are necessitated, case managers work closely with members to identify appropriate providers, schedule visits, and secure transportation. The plan also has a provider incentive program that supports case management objectives and which incentivizes providers to coordinate closely with the member and plan on specified quality measures.

Members of our Special Needs Plan have a defined Model of Care (See Model of Care Section) that includes Provider Training. Our case management program includes initiatives specific to this population and our case managers provide support to resolve the special needs of this population. As a provider, the need to coordinate benefits available from Medicare and Medicaid may occur with our Special Needs Program members. Our Summary of Benefits available on our website defines the benefits for your state and the case management staff can assist with identifying resources and providing support to assure coordination.

**Communications**

Cigna-HealthSpring provides multiple communication channels to members. The plan maintains a full-service inbound call program that allows members to inquire about all aspects of their relationship with the plan. Outbound member services and care management calls are also made regularly to members to encourage them to participate in clinical programs and assessment activities provided as part of their health care benefit. In addition to telephonic touch points, the plan regularly sends educational materials to members in response to identified care gaps and changes in health status. Members also have access to web-based materials, where they can learn more about their benefits, explore additional benefits, search the provider directory, find a pharmacy, query the formulary, and identify the time and location of sales sessions.

**Program Evaluation**

Cigna-HealthSpring continually monitors the Program, and makes changes as needed to its structure, content, methods, and staffing. Changes to the Program are made under two conditions: (1) changes must benefit members; and (2) changes must be in compliance with
applicable regulations and guidance. Changes to the Program are accompanied by policy and procedure revisions and staff training as required. The Program operates under the umbrella of the plan’s Quality Improvement Committee which reports to the Corporate Quality Improvement Committee. It is reviewed and updated annually in collaboration with the Quality Improvement Department. The plan’s Physician Advisory Committee made up of network providers, also reviews the Program and its clinical guidelines at certain intervals and provides improvement recommendations.

Confidentiality

Cigna-HealthSpring is committed to preserving the confidentiality of its members and practitioners. Written policies and procedures are in place to ensure the confidentiality of member information. Patient data gathered during the case management process are available for the purposes of review only and are maintained in a confidential manner. Employees receive confidentiality training that includes appropriate storage and disposal of confidential information. Employees also sign a confidentiality agreement at the time of their initial company orientation.

Continuity of Care

Cigna-HealthSpring’s policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. When a practitioner leaves Cigna-HealthSpring’s network and a member is in an active course of treatment, our Health Services staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter. Members in their second or third trimester of pregnancy have access to the exiting provider through the postpartum period.

If the Plan terminates a participating provider, Cigna-HealthSpring will work to transition a member into care with a Participating Physician or other provider within Cigna-HealthSpring’s network. Cigna-HealthSpring is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

Cigna-HealthSpring also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in Cigna-HealthSpring’s network. Under these circumstances, Cigna-HealthSpring will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

Cigna-HealthSpring will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals, and any other on-going services) initiated prior to a new member’s enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Prior Authorization Department at 1-800-511-6932.

SPECIAL NEEDS PLAN - MODEL OF CARE

Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special healthcare needs.

The three specific groups are:

- “Dual eligible” beneficiaries (individuals who are eligible for both Medicaid & Medicare);
- Individuals with Chronic conditions; and
- Individuals who are residents of long term care facilities or require that level of care and reside in the community.

In 2008, CMS issued the final regulation “Medicare Improvements for Patients and Providers Act of 2008,” known as “MIPPA.” This regulation mandated that all Special Needs Plans have a filed and approved Model of Care by January 1, 2010.

The Model of Care is an evidenced-based process by which we integrate benefits and coordinate care for members enrolled in Cigna-HealthSpring’s Special Needs Plans. The Model of Care facilitates the early assessment and identification of health risks and major changes in the health status of members with complex care needs as well as the coordination of care to improve their overall health.

Cigna-HealthSpring’s Special Needs Plan Model of Care has the following goals:

- Improve access to medical, mental health, and social services;
- Improve access to affordable care;
- Improve coordination of care through an identified point of contact;
- Improve transitions of care across healthcare settings and providers;
- Improve access to preventive health services;
- Assure appropriate utilization of services; and
- Improve beneficiary health outcomes.
Importantly, the Model of Care focuses on the individual SNP member. SNP members receive a health risk assessment within 90 days of enrollment and annually thereafter. Based on the results of this assessment, an individualized care plan is developed using evidence-based clinical protocols. All SNP members must have an individualized care plan.

An interdisciplinary care team, which includes PCPs and practitioners of various disciplines and specialties, based on the needs of the member, is responsible for care management and supports the assessment and care planning process. The member may participate in this process, as may all healthcare providers. The individualized care plan is recorded centrally so that it may be shared with all members of the interdisciplinary care team, as indicated. All providers are encouraged to participate in the SNP Model of Care and interdisciplinary care teams.

Cigna-HealthSpring uses a data-driven process for identifying the frail/disabled, multiple chronic illnesses and those at the end of life. Risk stratification and protocols for intervention around care coordination, barriers to care, primary care givers, education, early detection, and symptom management are also components of the Model of Care. Based on the needs of plan members, a specialized provider network is available to assure appropriate access to care, complementing each member’s primary care provider.

Execution of the Model of Care is supported by systems and processes to share information between the health plan, healthcare providers and the member. The SNP Model of Care includes periodic analysis of effectiveness, and all activities are supported by the Quality Improvement Program.

For Dual SNP members:
Providers may contact our Health Risk Assessment department to request patients’ HRA results at 1-800-331-6769.
To discuss and/or request a copy of a patient’s care plan, refer a patient for an Interdisciplinary Care Team meeting or participate in an Interdisciplinary Care Team meeting, please contact our Case Management department at 1-888-501-1116.

For Chronic SNP members:
Providers may contact our Health Risk Assessment department to request patients’ HRA results at 1-800-331-6769.
To discuss and/or request a copy of a patient’s care plan, refer a patient for an Interdisciplinary Care Team meeting or participate in an Interdisciplinary Care Team meeting, please contact our Case Management department at 1-888-501-1116.

**REFERRAL PROCESS**
Please use the Referral Forms provided by Cigna-HealthSpring for all referrals to Specialists and Ancillary Service Providers. Each month, your office will be provided with a listing of the participating physicians and ancillary service providers within you Cigna-HealthSpring POD. This roster is to be consulted when a referral form is generated.

**Referral Documentation**
All referrals should contain the following information to be considered complete:

- Demographic information should include: Patient Name, Member ID Number, Date of Birth, and Health Plan
- Referring Physician’s name and telephone number
- Provisional diagnosis
- Brief clinical note or copy of pertinent chart notes
- Summary or attachment of pertinent lab and x-ray results
- List of treatments provided to date
- Signature of Referring Provider (Not a signature stamp)

There are two different types of referral forms:

- Pre Cert forms are to be used when referring a patient to one of the specialists or ancillary service providers that are identified on the current roster. These providers may be referred to without an authorization number from Cigna-HealthSpring. However, the member must present the referral form to the provider before services may be rendered.
- Prior Authorization forms are to be used when referring a patient to a specialist or ancillary service provider that is not listed on the physician roster, or an outpatient procedure. An authorization number must be obtained from Cigna-HealthSpring before this referral may be issued. Again, the member must present the referral form to the provider before services may be rendered.

It is extremely important that all pertinent information be noted on the referral forms, including patient history, past treatment, and provisional diagnosis. Attach copies of applicable test results to the referral forms.

**Authorization Notification Process**
1. All appropriate parties will be notified of non-behavioral health UM decisions.
2. The Primary Care Physician and/or requesting provider/vendor shall be notified of decision by fax or telephone within one business day of the decision.
3. Cigna-HealthSpring or other appropriate parties shall be notified of authorizations by daily reports in a mutually agreeable format. Urgent/emergent requests shall be handled by telephone.

Referral Process

When referring a member on a Pre Cert Form, the following procedures are to be used:

- Referring physician determines the need for a referral.
- The Pre Cert Form is filled out appropriately, listing or attaching all applicable studies to aid the specialist in his/her consultation with the patient. The referral should be for a consultation or consultation and treat only. This allows the specialist the flexibility to determine the appropriate treatment plan.
- Note on the form the expiration date of the referral. This date is ninety (90) days from the date the referral is issued. Eligibility should be re-verified by contacting the health plan of the member. The PCP will verify eligibility by consulting their most current eligibility list or by contacting Cigna-HealthSpring. The referral form covers one (1) visit unless otherwise indicated.
- Retain a copy of the form for the patient’s file. The remaining parts of the form should accompany the patient to the specialist’s or ancillary service provider’s facility.
- The form for Pre Cert and Prior Authorization is forwarded to HealthSpring. This may be accomplished via fax at:
  - Cigna-HealthSpring Precert
    Toll Free: 1-800-511-6932
    Local: 1-832-553-3456
    Toll Free Fax: 1-888-856-3969
    Local Fax: 1-832-553-3426
  - Home Health/DME
    Toll Free: 1-800-511-6932
    Local: 1-832-553-3313
    Toll Free Fax: 1-888-205-8658
- If your office does not have a fax machine, provide the information verbally via phone.
- Please allow adequate time for an authorization to be received. It is important not to schedule appointments or procedures until after an authorization has been given. Response to referral requests will generally be given according to the following timeline:
  - Emergent: Provide immediate care to the patient and contact Cigna-HealthSpring as soon as possible, at least within twenty-four (24) hours
  - Urgent: Authorization should be received within twenty-four (24) hours
  - Elective: Authorization processing within two (2) business days once all necessary information has been received
- If Cigna-HealthSpring approves the referral, you receive an authorization number via fax machine or phone. This authorization number should be reflected on the referral form that the patient will present to the specialist’s or ancillary service provider’s office. Without this authorization number, a patient’s services may be delayed or even denied.
- Prior to and after a referral is denied, the referring physician has the option to discuss the case with the Chief Medical Officer or reviewing physician.
- If treatment beyond the scope of the referral is deemed necessary by the specialist or ancillary service provider, Cigna-HealthSpring should be consulted prior to recommending treatment to the member or proceeding with the treatment plan. Do not schedule or encourage the patient to schedule an appointment before the authorization has been given.

Please note that a specialist may refer a patient for diagnostic testing using the appropriate referral process.

Referral Renewal Process for Specialist Offices

When a Cigna-HealthSpring Referral Form has expired due to:

1. The time period expiring, or;
2. The number of visits have expired
The specialist office may obtain a new Referral Form based on the procedure below:

- Prior Authorization/Pre Cert
  - Send a Referral Request to Cigna-HealthSpring stating the reason(s) for the continued treatment and the continued treatment request will be considered.
  - Please attach any pertinent office notes or test results.
  - If approved, either the expired authorization date will be extended or a new authorization will be created and faxed back to the requesting specialist.
  - Please allow forty-eight (48) hour turnaround time on these referrals.
- Non Authorization
  - Prior to any consultation or treatment by a specialist, it is the responsibility of the member and the specialist to assure that a member’s Referral Form has not expired.
Please contact your Administrator or Medical Director if you have any questions about this process.

Facility Notifications

Upon approval of an outpatient surgery or inpatient elective stay, Cigna-HealthSpring shall notify, via fax, the requesting provider, the preferred network facility, and the health plan of the decision. The notification is completed within one (1) business day of the decision.

“Out-of-Network Referrals” are those referrals for services or other health care providers who are not contracted with Cigna-HealthSpring. If a participating specialist is qualified to treat the member and the member can reasonably be by that specialist, Cigna-HealthSpring policy state that the participating specialist receives the referral. If you are unsure whether the provider is in-network, please contact Cigna-HealthSpring before making the referral.

An out-of-network referral may be made only if the required specialty or services are not available at the time the service is needed, or the member cannot reasonably be expected to see that physician (i.e. the distance to be traveled to the consult is greater than 100 miles). If for these reasons, an out-of-network physician or provider must be utilized, prior authorization by Cigna-HealthSpring is required.

Self Referral

Please refer to Cigna-HealthSpring’s website to view the current provider directory for Participating Specialists. If a member has a preference, the PCP should accommodate this request if possible. The only exceptions where the member may self refer are:

- To a Participating Gynecologist for annual gynecological exam except for infertility and to see a non-participating OB/GYN. The PCP may perform the annual exam if agreed upon by the member.
- Mental health referrals to Cigna-HealthSpring’s Behavioral Health Care
- Vision Exams – Members who have a Vision benefit may self refer to a participating provider
- Dental Coverage – Members who have a dental benefit may self refer to a Participating Dental provider

INPATIENT MANAGER PROGRAM

In certain Cigna-HealthSpring markets, Members admitted to participating facilities should be assigned to the designated Inpatient Manager (IPM) for coordination of care throughout the entire stay. Facilities will receive notice of the designated Inpatient Manager and are required to follow the proper protocol of assigning Cigna-HealthSpring members to the designated IPMs.

CIGNA HOME DELIVERY PHARMACY

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

1 Cigna Analysis, 2011

QUALITY MANAGEMENT PROGRAM

Overview

Quality Management Program Principles for Cigna-HealthSpring:

1. Provide services that are clinically driven, cost effective, and outcome oriented;
2. Provide services that are culturally informed, sensitive, and responsive;
3. Provide services that enable members to live in the least restrictive, most integrated community setting appropriate to meet their health care needs;
4. Ensure that guidelines and criteria are based on professional standards and evidence-based practices that are adapted to account for regional, rural, and urban differences;
5. Foster an environment of quality of care and service within Cigna-HealthSpring and through our Provider Partners; and

6. Promote member safety as an overriding consideration in decision making.

Cigna-HealthSpring is committed to providing access to quality health care for all members in all product lines through the continuous planning, implementation, assessment to improve the quality of care and services to our members. The Quality Management Program assumes that there is no permanent threshold for good performance. Our members expect and should be provided a comprehensive and therapeutic health care delivery system that is always evolving and improving.

The Quality Management Program accomplishes this by integrating, analyzing, and reporting on data from across the Plan as well as other data sources. The Quality Management Program prioritizes quality initiatives based on relevance to the population Cigna-HealthSpring serves, and works with other departments to manage plan resources in the most cost effective manner to maximize patient health outcomes. The following is a brief overview of the Quality Management Program’s functions.

• Collects and investigates internal and external reporting of quality of care concerns. Substantial quality concerns are presented to the Quality Improvement Committee (QIC) to formulate corrective action plans and monitor the results.

• Coordinates and facilitates Quality Improvement activities. The QIC is charged with providing oversight (identification, prioritization, and coordination) of all quality improvement activities related to the care and services provided to our members.

• Coordinates with various internal departments in preparation for mandatory Centers for Medicare and Medicaid Services (CMS) and state activities, such as Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Health Outcomes Survey (HOS).

• Works to encourage optimal health outcomes for our members through annual review of best practice standards. Preventive standards are leveraged from The United States Preventive Services Task Force Standards (USPSTF), which standards are derived from the American Diabetes Association, the American Cancer Society as well as other nationally recognized organizations. Guidelines for preventive and chronic care are revised and modified to reflect the latest in clinical best practices.

If you have any questions about Cigna-HealthSpring’s Quality Management Program or would like a comprehensive description of the Program, its Annual Goals, or a list of activities toward achieving those goals, please feel free to contact Customer Service. Information will be provided upon request.

Quality Management Program

Goal: To assure timely access to and availability of appropriate quality services for the population served by Cigna-HealthSpring.

• Objective: Ensure services are provided by qualified individuals and organizations including those with the qualifications and experience appropriate to service members with special needs especially those residing in a community setting at a long term care level of care.

• Objective: Ensure the safety of all members in all treatment settings.

• Objective: Improve the health service delivery system by implementing procedures and policies to conduct access, availability, quality, utilization, care coordination, credentialing, compliance, and fiscal monitoring using defined standards.

• Objective: Improve the medical and behavioral health of individuals served by Cigna-HealthSpring.

Goal: To encourage and mentor provider and plan staff in the implementation of the Quality Management Program and methods to ensure compliance with Cigna-HealthSpring policies, procedures and standards, and to support a provider and community culture of quality improvement.

• Objective: Improve the ability of all Cigna-HealthSpring staff to apply quality methodology through a program of education, training, and mentoring.

• Objective: Improve performance measures tied to provider reimbursement.

• Objective: Improve member and provider satisfaction.

• Objective: Ensure adequate infrastructure and resources to support the Quality Management Program.

Goal: To assure community involvement in maintaining and improving the health of Cigna-HealthSpring members, through a comprehensive community/provider partnership.

• Objective: Improve the quality of all activities through the education of staff, providers, members, and the community in best practices/evidence-based practices.
Objective: Improve the level of customer service and communication both internal and external.

Objective: Improve the coordination and collaboration of care among providers, and between Cigna-HealthSpring and providers, especially between physical and behavioral health providers.

Goal: Improve Health Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Provider Satisfaction scores and utilize these measures throughout the organization as quality outcomes.

Quality Improvement Committee (QIC)
The QIC is responsible for the overall design and implementation of quality improvement activities for the Cigna-HealthSpring organization, as well as for the oversight of quality improvement activities carried out by other quality sub-committees. The QIC reports these activities to the Board of Directors. The QIC ensures that member and provider feedback and recommendations are used when designing activities to improve care and services.

Comprehensive Medical Chart Reviews
Medicare Advantage organizations are required to meet CMS standards for data submission and coding accuracy. To ensure that we are meeting CMS requirements, Cigna-HealthSpring designated staff will request access to and conduct periodic reviews of selected records. These reviews are to ensure we have thorough, accurate information on all members from a coding and quality perspective. This is only a review of clinical information and will not be used for the purpose of making any adjustments to claims reimbursement.

CORPORATE COMPLIANCE PROGRAM
Overview
The purpose of Cigna-HealthSpring’s Corporate Compliance Program is to articulate Cigna-HealthSpring’s commitment to compliance. It also serves to encourage our employees, contractors, and other interested parties to develop a better understanding of the laws and regulations that govern Cigna-HealthSpring’s operations. Further, Cigna-HealthSpring’s Corporate Compliance Program also ensures that all practices and programs are conducted in compliance with those applicable laws and regulations.

Cigna-HealthSpring and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines Cigna-HealthSpring’s business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its members. Cigna-HealthSpring and its employees are also committed to meeting all contractual obligations set forth in Cigna-HealthSpring’s contracts with the Centers for Medicare and Medicaid Services (CMS). These contracts allow Cigna-HealthSpring to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program is designed to prevent violations of federal and state laws governing Cigna-HealthSpring’s lines of business, including but not limited to, health care fraud and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution, and, when necessary, disclosure to the appropriate governmental authorities.

Cigna-HealthSpring has in place policies and procedures for coordinating and cooperating with MEDIC (Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices, and law enforcement. Cigna-HealthSpring also has policies that delineate that Cigna-HealthSpring will cooperate with any audits conducted by CMS, MEDIC or law enforcement or their designees.

Fraud, Waste, and Abuse
Cigna-HealthSpring has policies and procedures to identify fraud, waste, and abuse in its network, as well as other processes to identify overpayments within its network to properly recover such overpayments. These procedures allow us to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 C.F.R. § 422.503(b)(4)(vi) and 42 C.F.R. § 423.504(b)(4)(vi)(H), and Cigna-HealthSpring has policies and procedures in place for cooperating with CMS and law enforcement entities.

The evaluation and detection of fraudulent and abusive practices by Cigna-HealthSpring encompasses all aspects of Cigna-HealthSpring’s business and its business relationship with third parties, including health care providers and members. All employees, contractors, and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith.

Reports may be filed in the following manner:
To report suspected or detected Medicare program non-compliance please contact Cigna-HealthSpring’s Compliance Department at:

- Cigna-HealthSpring
  Attn: Compliance Department
  9009 Carothers Parkway, Suite B-100
  Franklin, TN 37067
To report potential fraud, waste, or abuse please contact Cigna-HealthSpring’s Benefit Integrity Unit at:

- **By mail:**
  - Cigna-HealthSpring  
    Attn: Benefit Integrity Unit  
    500 Great Circle Road  
    Nashville, TN 37228

- **By phone:**
  - 1-800-230-6138  
    Monday through Friday, 8 a.m. to 6 p.m. CST

All such communications will be kept as confidential as possible but there may be times when the reporting individual’s identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or other party that reports compliance concerns in good faith can do so without fear of retaliation.

In addition, as part of an ongoing effort to improve the delivery and affordability of health care to our members, Cigna-HealthSpring conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9 and HCPCS, codes billed by our providers. The analysis allows Cigna-HealthSpring to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. Cigna-HealthSpring will review your coding and may review medical records of providers who continue to show significant variance from their peers. Cigna-HealthSpring endeavors to ensure compliance and enhance the quality of claims data, a benefit to both Cigna-HealthSpring’s medical management efforts and our provider community. As a result, you may be contacted by Cigna-HealthSpring’s contracted partners to provide medical records to conduct reviews to substantiate coding and billing.

**In order to meet your FWA obligations, please take the following steps:**

- Review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.
- Complete the mandatory online training at:
  - [https://cms.meridianksi.com/kc/main/pop_up_frm.asp?loc=/klic/course_info_enroll_info.asp%3Fpreview%3DFalse%26crs_ident%3DC200%26Cheight%3D100&strTable=undefined&strContentID=undefined](https://cms.meridianksi.com/kc/main/pop_up_frm.asp?loc=/klic/course_info_enroll_info.asp%3Fpreview%3DFalse%26crs_ident%3DC200%26Cheight%3D100&strTable=undefined&strContentID=undefined)

You may request a copy of the Cigna-HealthSpring Compliance Program document by contacting your Cigna-HealthSpring Provider Relationship Representative.

**MEDICARE ADVANTAGE PROGRAM REQUIREMENTS**

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

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

2. **Privacy and Confidentiality Safeguards.** Provider shall safeguard the privacy and confidentiality of members and shall ensure the accuracy of the health records of members. Provider shall comply with all state and federal laws and regulations and administrative guidelines issued by CMS pertaining to the confidentiality, privacy, data security, data accuracy and/or transmission of personal, health, enrollment, financial and consumer information and/or medical records (including prescription records) of members, including, but not limited to, the Standards for Privacy of Individually Identifiable Information promulgated pursuant to the Health Insurance Portability and Accountability Act.

3. **Member Hold Harmless.** Provider shall not, in any event (including, without limitation, non-payment by Cigna-HealthSpring or breach of the Agreement), bill, charge, collect a deposit from, seek compensation or remuneration or reimbursement from or hold responsible, in any respect, any member for any amount(s) that Cigna-HealthSpring...
may owe to provider for services performed by provider under the Agreement. This provision shall not prohibit provider from collecting supplemental charges, co-payments or deductibles specified in the Benefit Plans. Provider agrees that this provision shall be construed for the benefit of the member and shall survive expiration, non-renewal or termination of the Agreement regardless of the cause for termination.

4. **Delegation of Activities or Responsibilities.** To the extent activities or responsibilities under a CMS Contract are delegated to provider pursuant to the Agreement (“Delegated Activities”), provider agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by Cigna-HealthSpring; and (ii) in the event that the Cigna-HealthSpring or CMS determine that provider has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable State and/or Federal laws and regulations and CMS instructions, then Cigna-HealthSpring shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of Cigna-HealthSpring. To the extent that the Delegated Activities include professional credentialing services, provider agrees that the credentials of medical professionals affiliated or contracted with provider will either be (i) directly reviewed by Cigna-HealthSpring, or (ii) provider’s credentialing process will be reviewed and approved by Cigna-HealthSpring and Cigna-HealthSpring shall audit provider’s credentialing process on an ongoing basis. Provider acknowledges that Cigna-HealthSpring retains the right to approve, suspend or terminate any medical professionals, as well as any arrangement regarding the credentialing of medical professionals. In addition, provider understands and agrees that Cigna-HealthSpring maintains ultimate accountability under its Medicare Advantage contract with CMS. Nothing in this Agreement shall be construed to in any way limit Cigna-HealthSpring’s authority or responsibility to comply with applicable regulatory requirements.

5. **Prompt Payment.** Cigna-HealthSpring agrees to pay provider in compliance with applicable state or federal law following its receipt of a “clean claim” for services provided to Cigna-HealthSpring members. For purposes of this provision, a clean claim shall mean a claim for provider services that has no defect or impropriety requiring special treatment that prevents timely payment by Cigna-HealthSpring.

6. **Compliance with Cigna-HealthSpring’s Obligations, Provider Manual, Policies and Procedures.** Provider shall perform all services under the Agreement in a manner that is consistent and compliant with Cigna-HealthSpring’s contract(s) with CMS (the “CMS Contract”). Additionally, provider agrees to comply with the Cigna-HealthSpring Provider Manual and all policies and procedures relating to the Benefit Plans.

7. **Subcontracting.** Cigna-HealthSpring maintains ultimate accountability for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of Cigna-HealthSpring. Every subcontract between provider and a subcontractor shall (i) be in writing and comply with all applicable local, State and federal laws and regulations; (ii) be consistent with the terms and conditions of this Agreement; (iii) contain Cigna-HealthSpring and member hold harmless language as set forth in Section 3 hereof; (iv) contain a provision allowing Cigna-HealthSpring and/or its designee access to such subcontractor’s books and records as necessary to verify the nature and extent of the Covered Services furnished and the payment provided by provider to subcontractor under such subcontract; and (v) be terminable with respect to members or Benefit Plans upon request of Cigna-HealthSpring.

8. **Compliance with Laws.** Provider shall comply with all State and Federal laws, regulations and instructions applicable to provider’s performance of services under the Agreement. Provider shall maintain all licenses, permits and qualifications required under applicable laws and regulations for provider to perform the services under the Agreement. Without limiting the above, Provider shall comply with Federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (section 1128B(b) of the Social Security Act).

9. **Program Integrity.** Provider represents and warrants that provider (or any of its staff) is not and has not been (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for
participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider shall notify Cigna-HealthSpring immediately if, at any time during the term of the Agreement, provider (or any of its staff) is (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider acknowledges that provider’s participation in Cigna-HealthSpring shall be terminated if provider (or any of its staff) is debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services.

10. **Continuation of Benefits.** Provider shall continue to provide services under the Agreement to members in the event of (i) Cigna-HealthSpring’s insolvency, (ii) Cigna-HealthSpring’s discontinuation of operations or (iii) termination of the CMS Contract, throughout the period for which CMS payments have been made to Cigna-HealthSpring, and, to the extent applicable, for members who are hospitalized, until such time as the member is appropriately discharged.

11. **Incorporation of Other Legal Requirements.** Any provisions now or hereafter required to be included in the Agreement by applicable Federal and/or State laws and regulations or by CMS shall be binding upon and enforceable against the parties to the Agreement and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this Manual or elsewhere in your Agreement.

12. **Conflicts.** In the event of a conflict between any specific provision of your Agreement and any specific provision of the Manual, the specific provisions of this Manual shall control.

**DISPUTE RESOLUTION**

Any controversy, dispute or claim arising out of or relating to your Provider Agreement (“Agreement”) or the breach thereof, including any question regarding its interpretation, existence, validity or termination, that cannot be resolved informally, shall be resolved by arbitration in accordance with this Section, provided however that a legal proceeding brought by a third party against Cigna-HealthSpring, an Affiliate, provider, or any provider (“Defendant”), any cross-claim or third party claim by such Defendant against Cigna-HealthSpring, an Affiliate, provider, or any provider Facility shall not be subject to arbitration. In the event arbitration becomes necessary, such arbitration shall be initiated by either Party making a written demand for arbitration on the other Party. The arbitration shall be conducted in the county where the majority of the services are performed, in accordance with the Commercial Arbitration Rules of the American Arbitration Association, as they are in effect when the arbitration is conducted, and by an arbitrator knowledgeable in the health care industry. The Parties agree to be bound by the decision of the arbitrator. The Parties further agree that the costs, fees and expenses of arbitration will be borne by the non-prevailing party. Notwithstanding this Agreement to arbitrate, Cigna-HealthSpring, an Affiliate, provider, or any provider Facility may seek interim and/or permanent injunctive relief pursuant to this Agreement in the county where the majority of the services are performed in any court of competent jurisdiction. With respect to disputes arising during the life of this Agreement, this Section shall survive the termination or expiration of the Agreement.
APPENDIX
Prior Authorization (PA) Requirements
This Cigna-HealthSpring Prior Authorization list supersedes any lists that have been previously distributed or published—older
lists are to be replaced with the latest version.

Cigna-HealthSpring Prior Authorization (PA) Policy
PCP’s or referring providers should OBTAIN Prior Authorization BEFORE services requiring Prior Authorizations are rendered.
Prior Authorizations may be obtained via HealthSpring Connect (HSC) or as otherwise indicated in the Health Services section of
the 2014 Provider Manual. Please see the HealthSpring Connect section of the Provider Manual for an overview of the HSC
portal capabilities and instructions for obtaining access.

Rendering Providers should VERIFY that a Prior Authorization has been granted BEFORE any service requiring a Prior
Authorization is rendered. Prior Authorizations may be verified via HealthSpring Connect (HSC) or as otherwise indicated in the
Health Services section of the Provider Manual.

IMPORTANT – Prior Authorization and/or Referral Number(s) is/are not a guarantee of benefits or payment at the time of
service. Remember, benefits will vary between plans, so always verify benefits.

Cigna-HealthSpring Referral Policy
Cigna-HealthSpring values the PCP’s role in directing the care of Members to the appropriate, participating Providers.
Participating Specialists are contracted to work closely with our referring PCPs to enhance the quality and continuity of care
provided to Cigna-HealthSpring Members.

Although a Prior Authorization may not be required for certain services, a REFERRAL from a PCP to a Specialist MUST BE in
place. The Referral should indicate PCP approved for a consultation only or for consultation and treatment, including the
number of PCP approved visits.

Refer to the online directory at www.cignahealthspring.com or contact Provider Services, toll-free phone: (800) 230-6138 to
locate an in-network provider.

<table>
<thead>
<tr>
<th>Procedures/Services</th>
<th>PA Required</th>
<th>PA Not Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>![Yes]</td>
<td>![No withheld]</td>
<td>Inpatient Admission: Yes, Prior Auth required</td>
</tr>
<tr>
<td></td>
<td>![Yes]</td>
<td>![No withheld]</td>
<td>Inpatient Observation: Yes, Prior Auth required</td>
</tr>
<tr>
<td></td>
<td>![Yes]</td>
<td>![No withheld]</td>
<td>Inpatient Rehabilitation: Yes, Prior Auth required</td>
</tr>
<tr>
<td></td>
<td>![Yes]</td>
<td>![No withheld]</td>
<td>Skilled Nursing Facility: Yes, Prior Auth required</td>
</tr>
<tr>
<td></td>
<td>![Yes]</td>
<td>![No withheld]</td>
<td>LTAC: Yes, Prior Auth required</td>
</tr>
<tr>
<td></td>
<td>![Yes]</td>
<td>![No withheld]</td>
<td>Intermediate Care Facility/Assisted Living: Yes, Prior Auth required</td>
</tr>
<tr>
<td>Allergy Injections without a MD visit</td>
<td>![X]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Serum and Testing</td>
<td>![X]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance (Air or Ground)</td>
<td>![See Comments]</td>
<td>![See Comments]</td>
<td>Non-Emergent Transports: Yes, Prior Auth required</td>
</tr>
<tr>
<td></td>
<td>![See Comments]</td>
<td>![See Comments]</td>
<td>Emergent Transports: No, Prior Auth not required</td>
</tr>
</tbody>
</table>

Revised 06/01/2014
<table>
<thead>
<tr>
<th>Procedures/Services</th>
<th>PA Required</th>
<th>PA Not Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (Air or Ground) cont.</td>
<td>See Comments</td>
<td>Facility to Facility Transfer</td>
<td>Yes, Prior Auth required</td>
</tr>
<tr>
<td>Amniocentesis</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Angioplasty/Cardiac</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Catheterization/Stents (cardiac and renal)</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Arteriogram/Angiogram</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Audiogram</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Biopsy</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Blood Services (Outpatient)</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Bone Density Study</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Cardiac Monitoring</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td></td>
<td>✔️</td>
<td>Only covered for specific conditions under Medicare guidelines</td>
</tr>
<tr>
<td>Cardiac Testing</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Cardioversion</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>✔️</td>
<td>✗</td>
<td>Initial treatment only</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>✔️</td>
<td>✗</td>
<td>Only covered for specific conditions under Medicare guidelines</td>
</tr>
<tr>
<td>CT Scans</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>• Fast (EBCT)</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>• 64 Slice</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>• CTA Scans – all modalities</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies and Monitors</td>
<td>✔️</td>
<td>✗</td>
<td>Prior Auth required if provided under Part B benefits</td>
</tr>
<tr>
<td>Doppler/Duplex Studies</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>See Comments</td>
<td>Facility to Facility Transfer</td>
<td>Prior Authorization is Required For:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• All rental DME</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Purchased DME with billed charges, per line item, greater than $500;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>certain items require Prior Auth regardless of price</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• All supplies with billed charges, per line item, greater than $500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• All repairs to DME</td>
</tr>
<tr>
<td>Echocardiogram (ECG)</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Electrocardiogram (EKG)</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Electroencephalogram (EEG)</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Electromyography (EMG)</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Electrophysiology (EP)</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>✔️</td>
<td>Includes diabetic education, nutritional counseling, and smoking cessation</td>
</tr>
<tr>
<td>Endoscopy</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Facility to Facility Transfers</td>
<td>✔️</td>
<td>✗</td>
<td>See ambulance</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td>✔️</td>
<td>✗</td>
<td>Only covered under certain conditions under Medicare guidelines</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Home Health Services</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Home Infusion</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>✔️</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Lab work</td>
<td></td>
<td>✔️</td>
<td>Must use contracted provider</td>
</tr>
<tr>
<td>MRA (all modalities)</td>
<td>✔️</td>
<td>✗</td>
<td>Requests for authorization should be directed to MedSolutions for approval</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="http://www.medsolutionsonline.com">www.medsolutionsonline.com</a> or 888-693-3211</td>
</tr>
</tbody>
</table>

Revised 06/01/2014
<table>
<thead>
<tr>
<th>Procedures/Services</th>
<th>PA Required</th>
<th>PA Not Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI (all modalities)</td>
<td>✔</td>
<td>☑️</td>
<td>Requests for authorization should be directed to MedSolutions for approval ¹ <a href="http://www.medsolutionsonline.com">www.medsolutionsonline.com</a> or 888-693-3211</td>
</tr>
<tr>
<td>Myelogram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear Cardiac Studies</td>
<td>✔</td>
<td>☑️</td>
<td>Requests for authorization should be directed to MedSolutions for approval ¹ <a href="http://www.medsolutionsonline.com">www.medsolutionsonline.com</a> or 888-693-3211</td>
</tr>
<tr>
<td>Nuclear Radiology Studies</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthotics</td>
<td>See Comments</td>
<td></td>
<td>Prior Authorization is Required For:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Purchased Orthotics with billed charges, per line item, greater than $500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• All repairs to Orthotics</td>
</tr>
<tr>
<td>Outpatient Observation</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgical Procedures</td>
<td>✔</td>
<td></td>
<td>Outpatient hospital and ambulatory surgical centers require prior authorization</td>
</tr>
<tr>
<td>Oxygen Equipment</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B Drugs</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peritoneal/Home Dialysis</td>
<td></td>
<td>☑️</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td>✔</td>
<td></td>
<td>Only covered for specific conditions under Medicare guidelines</td>
</tr>
<tr>
<td>Positron Emission Tomography (PET)</td>
<td>✔</td>
<td></td>
<td>Requests for authorization should be directed to MedSolutions for approval ¹ <a href="http://www.medsolutionsonline.com">www.medsolutionsonline.com</a> or 888-693-3211</td>
</tr>
<tr>
<td>Preventive Screenings</td>
<td></td>
<td>☑️</td>
<td>Include mammogram, pap test, colonoscopy, flu and pneumonia vaccines, bone density, glaucoma screening</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>See Comments</td>
<td></td>
<td>Prior Authorization is Required For:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Purchased Prosthetics with billed charges, per line item, greater than $500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• All repairs to Prosthetics</td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
<td></td>
<td>☑️</td>
<td>Only covered for specific conditions under Medicare guidelines</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>✔</td>
<td></td>
<td>Prior Auth only required for IMRT, Gamma knife, and Cyber knife</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>See Comments</td>
<td></td>
<td>In home setting ➔ Yes, Prior Auth required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>In hospital or outpatient setting ➔ No, Prior Auth not required</td>
</tr>
<tr>
<td>Sleep Study</td>
<td>See Comments</td>
<td></td>
<td>In home setting ➔ Yes, Prior Auth required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>In hospital or outpatient setting ➔ Yes, Prior Auth required</td>
</tr>
<tr>
<td>Specialty Services</td>
<td>✔</td>
<td></td>
<td>PCP Referral to Specialty Physician is required</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td>☑️</td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound Care (Physician Office or Outpatient Wound Center)</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray</td>
<td></td>
<td>☑️</td>
<td></td>
</tr>
</tbody>
</table>
1 MedSolutions Diagnostic Imaging Management Program will apply to membership in the following regions: ARFS, ARKL, DOC, EPIC, HOPE, INDT, LVPA, NTXH, NTXP, OKLA, SWTX, TXAR excluding HUM_PFFS/LPPO within TXAR, VIP. The program may or may not apply to IPA membership; please refer to your IPA directory for additional information.

2 DME requiring prior auth regardless of price – chest wall oscillation vest, conductive garment for TENS or NMES, cough stimulating device, cuirass chest shell, external defibrillator, gel pressure pad or non-powered pressure overlay for mattress, hydrocollator portable unit, implantable infusion pump, incontinent treatment system, pelvic floor stimulator, jaw motion rehab system, manual and power wheelchair cushions and accessories, osteogenesis stimulator, pneumatic compression device and/or any appliance to use with it, powered wheelchair or scooter, seat lift mechanism, shoulder flexion rotation device, speech generating device, TENS device, traction equipment
Cigna-HealthSpring is committed to providing our members with the highest quality and greatest value in healthcare benefits and services. Managing the behavioral health benefits of our members allows Cigna-HealthSpring the opportunity to demonstrate this commitment by recognizing overall needs and providing better care.

Cigna-HealthSpring will continue to offer the outpatient services listed below without the requirement of a prior authorization. Any service not listed will continue to utilize the standard authorization process.

## Services Requiring No Authorization by Participating Provider

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>DESCRIPTION</th>
<th>Report with Psychotherapy Add-On Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation (no medical services)</td>
<td></td>
</tr>
<tr>
<td>90792 (or New Patient E &amp; M codes)</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
<td></td>
</tr>
<tr>
<td><strong>Out Patient</strong></td>
<td><strong>New Patient Visit (10-60 min)</strong>&lt;br&gt;Established Patient (5-25 min)</td>
<td><strong>Psychotherapy Add On Codes:</strong>&lt;br&gt;(when appropriate)&lt;br&gt;90833-30 min&lt;br&gt;90836-45 min&lt;br&gt;90838-60 min</td>
</tr>
<tr>
<td>99201-99205</td>
<td>Micnusg Facility&lt;br&gt;999304-999306&lt;br&gt;99307-99310</td>
<td></td>
</tr>
<tr>
<td>99211-99215</td>
<td>New Patient Visit (10-45 min)&lt;br&gt;Established Patient (10-35 min)</td>
<td></td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy (30 min)</td>
<td></td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy (45 min)</td>
<td></td>
</tr>
<tr>
<td>90846</td>
<td>Family Psychotherapy (without patient present)</td>
<td></td>
</tr>
<tr>
<td>90847</td>
<td>Family Psychotherapy (with patient present)</td>
<td></td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy (other than of a multiple–family group)&lt;br&gt;&lt;i&gt;Physicians Office Only ~ Facilities Require Prior Authorization.&lt;/i&gt;</td>
<td></td>
</tr>
<tr>
<td>Q3014</td>
<td>Telehealth</td>
<td></td>
</tr>
</tbody>
</table>

### FUNCTION

<table>
<thead>
<tr>
<th>FUNCTION</th>
<th>PHONE/ADDRESS</th>
<th>DESCRIPTION OF SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Eligibility/Benefits</td>
<td>800-453-4464 (*IVR)</td>
<td>Verification of coverage and benefits; for facility admissions and other facility services, consult the Common Working File if member does present ID card.</td>
</tr>
<tr>
<td>Authorization Line</td>
<td>866-780-8546 Fax: 866-949-4846</td>
<td>Prior authorization is required for services not listed above.</td>
</tr>
<tr>
<td>Inpatient Admissions</td>
<td>866-780-8546 Fax: 866-949-4846</td>
<td>Notification is required within 24 hours of admissions; clinical staff available 24 hrs a day/7 days a week to assist with notifications and precertification.</td>
</tr>
<tr>
<td>Claims Submission (paper)</td>
<td>Cigna-HealthSpring Claims Dept P.O. Box 981804 El Paso, TX 79998-1706</td>
<td>Claims Submission (paper) Cigna-HealthSpring Claims Dept P.O. Box 981804 El Paso, TX 79998-1706</td>
</tr>
<tr>
<td>Claim Status Inquires</td>
<td>800-453-4464 (*IVR)</td>
<td>Access to on-line provider portal for verification of member eligibility, authorization, and claim payment review. Select Providers tab, then HSConnect to access portal.</td>
</tr>
<tr>
<td>HSConnect</td>
<td><a href="http://www.cignahealthspring.com">www.cignahealthspring.com</a></td>
<td>HSConnect <a href="http://www.cignahealthspring.com">www.cignahealthspring.com</a></td>
</tr>
</tbody>
</table>

*(IVR) Interactive Voice Response System

10/23/13
Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

**It’s About How You LIVE**

*It’s About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- Learn about options for end-of-life services and care
- Implement plans to ensure wishes are honored
- Voice decisions to family, friends and health care providers
- Engage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.
Using these Materials

BEFORE YOU BEGIN
1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
   • Instructions for preparing your advance directive, please read all the instructions.
   • Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS
1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
Introduction to Your Arkansas Declaration and Durable Power of Attorney for Health Care

This packet contains your Arkansas Declaration and Durable Power of Attorney for Health Care. This legal document protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Page 1 of your document contains your Declaration, which allows you to state your wishes about medical care in the event that you either: (1) develop a terminal condition and are unable to make your own medical decisions; or (2) are in a permanently unconscious state. The declaration becomes effective when you are in either of these states, your doctor and one other doctor has determined you are in such a state, and the declaration has been communicated to your doctor. Page 1 includes a space for you to include additional directions in the event you are terminally ill or permanently unconscious.

Pages 2 and 3 of your document contain your Arkansas Durable Power of Attorney for Health Care, which lets you name an Agent to make decisions about your medical care any time you lose the ability to make medical decisions for yourself. Page 3 of your document allows you to include directions in the event you lose the ability to make medical decisions for yourself. These directions are triggered any time you lose capacity, and are not dependent on you becoming terminally ill or permanently unconscious.

Your durable power of attorney for health care also appoints your agent as your Health Care Proxy to make decisions about your medical care — including decisions about life sustaining treatment — if you are terminally ill and can no longer make your own decisions about health care or are permanently unconscious.

Your durable power of attorney for health care goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Page 4 of your document is your signature page. Your signature must be witnessed by two people who are 18 years of age or older.

Note: This form authorizes mental health care decisions to be made by your agent/proxy, but does not go into detail regarding mental health issues. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney.

Following your Arkansas declaration and durable power of attorney for health care is an organ donation form.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).
Instructions for Completing Your Arkansas Declaration and Durable Power of Attorney

How do I make my Arkansas Declaration and Durable Power of Attorney for Health Care legal?

The law requires that you sign or someone signs at your direction on your behalf your Declaration and Durable Power of Attorney for Health in the presence of two witnesses, who must be 18 years of age or older.

Whom should I appoint as my Agent/Proxy?

Your agent/proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent/proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent/proxy should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. **To avoid any confusion, you should name the same person as your agent/proxy in the Directive section as you name in the Durable Power of Attorney section.**

You can appoint a second person as your alternate agent/proxy. The alternate will step in if the first person you name as an agent/proxy is unable, unwilling, or unavailable to act for you.

Can I add personal instructions to my Declaration?

One of the strongest reasons for naming an agent/proxy is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent/proxy carry out your wishes, but be careful that you do not unintentionally restrict your agent/proxy’s power to act in your best interest. In any event, be sure to talk with your agent/proxy about your future medical care and describe what you consider to be an acceptable “quality of life.”

What if I change my mind?

You may revoke the instructions in your declaration at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective when you (or a witness to your revocation) notify your doctor or other health care provider, who must then make the revocation a part of your medical record.

You may revoke your agent/proxy’s power under your durable power of attorney for health care at any time by executing a new durable power of attorney for health care or by otherwise specifying in writing that you wish to revoke it.
What other important facts should I know?

A pregnant patient’s Arkansas Declaration will not be honored if it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment.

Instructions for Completing Your Arkansas Organ Donation Form

How do I make my Arkansas Organ Donation Form legal?

The law requires that you sign your Organ Donation Form in the presence of two witnesses. Both witnesses must be 18 years of age or older. At least one of the witnesses must be a disinterested party (i.e. not a family member nor potential recipient of your donation).

Who may receive my anatomical gift?

Under Arkansas law, you may make a gift of all or part of your body for transplantation, therapy, research, or education to any of the following entities: a tissue or eye bank or any other organ procurement organization; hospital; accredited medical school, dental school, college, or university; or any individual designated as the recipient by you.

Can others make a gift for me?

Unless you explicitly prohibit such gifts, your agent/proxy or a family member has the authority to make anatomical gifts on your behalf.

Can I refuse to make a gift?

You can refuse to make a gift in any of these other ways: (1) any writing — including your Organ Donation Form — signed by you refusing to make such donations; (2) in your will; or (3) during a terminal illness or injury, you communicate such refusal to at least two adults, at least one of whom is a disinterested witness.

How can I revoke my gift?

You can revoke or amend an anatomical gift by: (1) any writing signed by you revoking or amending such gift that is witnessed by at least two adults, at least one of whom is a disinterested witness; (2) by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift. If the gift was not made in a will, you may revoke or amend it by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.
ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY
FOR HEALTH CARE — PAGE 1 OF 4

Declaration

If I should either (1) have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment; or (2) if I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to (initial only one)

- _______ 1. Withhold or withdraw treatments that only prolong the process of dying and are not necessary to my comfort or to alleviate pain.

- _______ 2. Follow the instructions of ________________________, whom I appoint as my health care agent/proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

In addition, the following specific directives apply (initial the option(s) that apply):

- _______ a. It is my specific directive that nutrition may be withheld after consultation with my attending physician.

- _______ b. It is my specific directive that hydration may be withheld after consultation with my attending physician.

- _______ c. It is my specific directive that nutrition may not be withheld.

- _______ d. It is my specific directive that hydration may not be withheld.

Other directions in the event I am terminally ill and cannot make decisions, or I am permanently unconscious:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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I, ________________________________, hereby (your name)

appoint:

____________________________________________________________

(name, home address and telephone number of agent/proxy)

as my health care agent/proxy to make any and all health care decisions for me, except to the extent that I state otherwise.

This Durable Power of Attorney for Health Care shall take effect in the event of my disability or incapacity, such that I become unable to make my own health care decisions. My health care agent/proxy and any alternate health care agent/proxy as appointed below shall have the authority to make all health care decisions regarding any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental health or personal care.

If I should either (1) have an incurable or irreversible condition that will cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment; or (2) if I should become permanently unconscious, my health care agent/proxy and any alternate health care agent/proxy shall also have the authority to make decisions regarding the providing, withholding, or withdrawing of life sustaining treatment as my Proxy pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

If the health care agent/proxy I appoint is unable, unwilling or unavailable to act as my health care agent/proxy, then I appoint:

____________________________________________________________

(name, home address and telephone number of alternate agent/proxy)

as my alternate health care agent/proxy to make any and all health care decisions for me, except to the extent that I state otherwise.
Other Directions, in the event of my disability or incapacitation, such that I become unable to make my own health care decisions:

________________________________________________________________________
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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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Signed this ______ day of ______________, ____________.
(day)                   (month)                           (year)

Signature__________________________________________________

Address _____________________________________________________

Statement by Witnesses (must be 18 or older):
I declare that the person who signed above appeared to execute this
declaration and durable power of attorney for health care willingly and
free from duress. He or she signed (or asked another to sign for him or
her) this document in my presence.

Witness _____________________________________________________
(Signature)             (Date)

_____________________________________________________
(Print name)

Address _____________________________________________________

Witness _____________________________________________________
(Signature)             (Date)

_____________________________________________________
(Print name)

Address _____________________________________________________

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898
Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Arkansas law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution: _______________________

_____ Pursuant to Arkansas law, I hereby give, effective on my death:

_____ Any needed organ or parts.

_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.

_____ Transplant or therapeutic purposes only.

Declarant name: ____________________________________________

Declarant signature: ____________________________, Date: __________

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness ____________________________ Date __________________

Address ____________________________________________

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness ____________________________ Date __________________

Address ____________________________________________

 Courtesy of Caring Connections
 1731 King St., Suite 100, Alexandria, VA 22314
 www.caringinfo.org, 800/658-8898

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You Have Filled Out Your Health Care Directive, Now What?

1. Your *Arkansas Declaration and Durable Power of Attorney for Health Care* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent/proxy and alternate agent/proxy, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent/proxy(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Arkansas document.

7. Be aware that your Arkansas document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called “prehospital medical care directives” or “do not resuscitate orders” are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining this form. **Caring Connections does not distribute these forms.**
Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It’s About How You LIVE

*It’s About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- Learn about options for end-of-life services and care
- Implement plans to ensure wishes are honored
- Voice decisions to family, friends and health care providers
- Engage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

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Using these Materials

BEFORE YOU BEGIN
1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
   - Instructions for preparing your advance directive, please read all the instructions.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS
1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
INTRODUCTION TO YOUR OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE

This packet contains a legal document, the **Oklahoma Advance Directive for Health Care**, that protects your right to refuse medical treatment you do not want or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may fill out Part I, Part II, Part III, or any or all of these parts, depending on your advance planning needs. You must complete Part V.

**Part I** of the Advance Directive is the **Living Will**. It lets you state your wishes about health care in the event that you can no longer make your own health care decisions and you are terminally ill, persistently unconscious, or have an end-stage condition.

Part I goes into effect when your doctor determines that you are no longer able to make your own decisions, and that you are terminally ill, persistently unconscious, or have an end-stage condition.

**Part II** is the **Appointment of Health Care Proxy**. This section lets you name someone to make decisions about your health care if you can no longer speak for yourself. Appointing a health care proxy can be especially useful, because your health care proxy’s authority is active whenever you cannot make decisions for yourself, not just at the end of life.

**Part III** addresses **Anatomical Gifts**. This Part allows you to indicate whether you want to donate any or all of your organs and tissues after your death.

**Part IV** contains general provisions regarding your advance directive for health care.

**Part V** contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

*Note: This document will be legally binding only if the person completing it is 18 years of age or older.*
INSTRUCTIONS FOR COMPLETING YOUR OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE

How do I make my Advance Directive legal?

The law requires that you sign your Oklahoma Advance Directive for Health Care in the presence of two witnesses who are at least eighteen years of age. Your witnesses cannot be related to you or be any person who can inherit from your estate.

Who should I pick as my health care proxy?

Your health care proxy is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your proxy should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate health care proxy. The alternate will step in if the first person you name as your health care proxy is unable, unwilling, or unavailable to act for you.

Should I add instructions to my advance directive for health care?

One of the strongest reasons for naming a health care proxy is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your health care proxy carry out your wishes, but be careful that you do not unintentionally restrict your health care proxy’s power to act in your best interest. In any event, be sure to talk with your health care proxy about your future medical care and describe what you consider to be an acceptable “quality of life.”

What if I change my mind?

You may revoke your Oklahoma Advance Directive for Health Care at any time and in any manner, regardless of your mental or physical condition. Your revocation is effective once you, or a witness to your revocation, notify your doctor or other health care provider.

What other important facts should I know?

Your Oklahoma Advance Directive for Health Care will not be honored if you are pregnant unless you have specifically authorized that life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn during pregnancy.
If I, ________________________________ (name), am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

Part I. Living Will

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below.

1. If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

   _______ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

   _______ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

   _______ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

2. If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

   _______ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

   _______ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

   _______ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.
3. If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

________ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

________ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

________ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.
4. Other. Here you may:
   (a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn;

   (b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition; or

   (c) do both of these.

   ______________________________________________________________
   ______________________________________________________________
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   ______________________________________________________________

(Attach additional pages, if needed.)
Part II. Appointment of my Health Care Proxy

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of

Name of health care proxy:_________________________________,
Address:_____________________________________________________
Telephone number:______________________________________________,

whom I appoint as my health care proxy. If my health care proxy is unable, unwilling, or not reasonably available to serve, I appoint

Name of alternate health care proxy:______________________________,
Address:_______________________________________________________
Telephone number:______________________________________________,

as my alternate health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able. However, my health care proxy or alternate health care proxy must make decisions consistent with any choices I have made in this document regarding life-sustaining treatment and artificially administered nutrition and hydration.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

When making health-care decisions for me, my health care proxy should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care proxy should make decisions for me that my health care proxy believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.
I further direct that:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

(Attach additional pages, if needed.)
Part III. Anatomical Gifts (Organ Donation)

Initial the line next to the choices below that best reflect your wishes. You do not have to initial any of the choices. If you do not initial any of the choices, your proxy, guardian, or other agent, or your family, may have the authority to make a gift of all or part of your body under Oklahoma law.

Pursuant to the provisions of the Oklahoma Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

- Transplantation
- Therapy
- Advancement of medical science, research, or education
- Advancement of dental science, research, or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. I specifically donate:

- My entire body, or
- The following organs or body parts:

  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________
Part IV. General Provisions

a. I understand that I must be eighteen (18) years of age or older to execute this form.

b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.

c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.

d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of any life-sustaining procedures, and I accept the consequences of such choice or refusal.

e. This advance directive shall be in effect until it is revoked.

f. I understand that I may revoke this advance directive at any time.

g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.

h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician’s profession in good standing engaged in the same field of practice at that time, measured by national standards.
Part V. Execution

Signed this _________ day of _________________________, 20 ______.

____________________________________________________________
(signature)

____________________________________________________________
(printed name)

____________________________________________________________
(city, county and state of residence)

Date of birth

Witnesses: This advance directive was signed in my presence.

Witness # 1

____________________________________________________________
(signature of witness) (date)

____________________________________________________________
(printed name)

____________________________________________________________
(address)

____________________________________________________________
(city, state and zip code)

Witness # 2

____________________________________________________________
(signature of witness) (date)

____________________________________________________________
(printed name)

____________________________________________________________
(address)

____________________________________________________________
(city, state and zip code)

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898
You Have Filled Out Your Health Care Directive, Now What?

1. Your Oklahoma Advance Directive for Health Care is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your proxy and alternate proxy, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your proxy(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Oklahoma document.

7. Be aware that your Oklahoma document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called “prehospital medical care directives” or “do not resuscitate orders” are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. Caring Connections does not distribute these forms.
Directive to Physicians and Family or Surrogates
Advance Directives Act (see §166.033, Health and Safety Code)

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of the document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

**Directive**

I ____________________________________, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgement of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (This selection does not apply to Hospice care.)

If, in the judgement of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (This selection does not apply to Hospice care.)
**Additional Requests:** (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do **not** have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values:
1. ____________________________
2. ____________________________

*(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)*

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me, following standards specified in the laws of Texas.

If, in the judgement of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed ____________________________ Date ______________
City, County and State of Residence ____________________________

---

*Two witnesses must sign in the spaces below.*

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as **Witness (1)** may not be a person designated to make a treatment decision for the patient and may not be related to the declarant by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness (1) ____________________________ Witness (2) ____________________________
Definitions:

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:
- that may be treated, but is never cured;
- that leaves a person unable to care for or make decisions for the person's own self; and
- that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgement, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgement will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.
Directiva a los médicos y a familiares o substitutos
Ley de Directivas Anticipadas (ver §166.033, del Código de Salud y Seguridad)

Éste es un documento legal importante conocido como Directiva Anticipada. Su función es ayudar a comunicar sus deseos relacionados con el tratamiento médico para un momento futuro cuando no esté en capacidad de hacer conocer sus deseos debido a una enfermedad o lesión. Estos deseos se basan generalmente en sus valores personales. En particular, querrá considerar qué nivel o dificultades de tratamiento está dispuesto a soportar a cambio del beneficio que obtendría en caso de estar gravemente enfermo.

Se le sugiere que hable sobre sus valores y deseos con su familia y con la persona escogida como su agente, lo mismo que con su doctor. El doctor, otro proveedor médico o una institución médica pueden ofrecerle algunos recursos para ayudarle a completar la directiva anticipada. A continuación se dan unas definiciones breves que le podrán ayudar en sus discusiones y en la planeación. Escriba sus iniciales al lado de las opciones de tratamiento que mejor reflejen sus preferencias personales. Deles una copia de su directiva a su doctor, a su hospital de costumbre, a sus parientes y a su agente. Haga una revisión periódica del documento. Mediante la revisión periódica, puede asegurar que la directiva refleje sus preferencias.

Además de esta directiva anticipada, la ley de Texas estipula otros dos tipos de directivas que pueden ser importantes en caso de una enfermedad grave. Estas son: el Poder médico y la Orden de no revivir fuera del hospital. Debe hablar sobre estos con el doctor, su familia, un representante del hospital o con otros consejeros. También es posible que desee llenar una directiva relacionada con la donación de órganos y tejidos.

**Directiva**

Yo, _______________________________, reconozco que la mejor atención médica se basa en una relación de confianza y comunicación con mi doctor. Juntos, mi doctor y yo tomaremos las decisiones médicas mientras yo esté en condiciones mentales de hacer conocer mis deseos. Si en algún momento yo no estoy en capacidad de tomar decisiones médicas respecto a mi salud debido a una enfermedad o lesión, ordeno que se respeten las siguientes preferencias respecto al tratamiento:

Si, a juicio de mi doctor, estoy padeciendo de una enfermedad terminal de la que se espera moriré dentro de los seis meses, incluso con tratamientos disponibles para prolongar la vida, suministrado de acuerdo con las normas actuales de atención médica:

___ Yo pido que no me den o que me retiren todo tratamiento salvo aquellos necesarios para mantenerme cómodo, y que mi doctor me deje morir tan dignamente como sea posible; O  

___ Yo pido que me mantengan con vida en esta situación terminal usando los tratamientos disponibles para prolongar la vida. (**Esta preferencia no se aplica al cuidado de hospicio**).

Si, a juicio de mi doctor, estoy sufriendo de un padecimiento irreversible, que no permitirá que me atienda yo mismo ni que tome decisiones por mí mismo y se espera que moriré si no me suministren tratamientos para prolongar la vida de acuerdo con las normas actuales de atención médica:
Yo pido que no me den o me retiren todo tratamiento salvo aquellos necesarios para mantenerme cómodo, y que mi doctor me deje morir tan dignamente como sea posible; O

Yo pido que me mantengan con vida en esta situación irreversible usando tratamientos disponibles para prolongar la vida. (Esta preferencia no se aplica al cuidado de hospicio).

Peticiones adicionales: (Después de consultárle al doctor, usted querrá escribir algunos tratamientos en el espacio disponible que usted quiera o no quiera que se le den bajo circunstancias específicas, como la nutrición artificial y los líquidos, los antibióticos por vía intravenosa, etc. Asegúrese de anotar si quiere o no quiere el tratamiento en particular).

Después de firmar esta directiva, si mi representante o yo elegimos cuidado de hospicio, entiendo y estoy de acuerdo en que me den solamente aquellos tratamientos para mantenerme cómodo y que no me den los tratamientos disponibles para prolongar la vida.

Si no tengo un poder para la atención médica, y no puedo dar a conocer mis deseos, designo a las siguientes personas para que tomen decisiones con mi doctor que sean compatibles con mis valores personales:

1. ___________________________________
2. ___________________________________

(Si usted ya ha firmado un poder médico, entonces ya habrá nombrado a un agente y no deberá anotar otros nombres en este documento).

Si las personas nombradas antes no están disponibles, o si no hay un vocero designado, comprendo que se escogerá un vocero para mí, siguiendo las pautas especificadas por la ley de Texas.

Si, a juicio de mi doctor, mi muerte es inminente dentro de minutos u horas, a pesar de que me den todo tratamiento médico disponible suministrado dentro de las pautas de atención actuales, autorizo que no me den o que me retiren todo tratamiento salvo aquellos necesarios para mantenerme cómodo. Comprendo que bajo la ley de Texas esta directiva no tiene efecto si se ha diagnosticado que estoy embarazada. Esta directiva seguirá en efecto hasta que yo la revoque. Nadie más puede hacerlo.

Firmado________________________________________ Fecha________________

Ciudad, condado y estado de domicilio

Dos testigos tienen que firmar en los espacios siguientes.

Dos testigos adultos hábiles tienen que firmar a continuación, reconociendo la firma del declarante. El testigo designado Testigo (1) no puede ser una de las personas designadas para tomar decisiones relacionadas con el tratamiento para el paciente y no puede estar relacionado con el declarante por sangre o por matrimonio. Este testigo no puede tener derecho a ninguna parte de la sucesión y no puede tener un reclamo en contra de la sucesión del paciente. Este
testigo no puede ser el médico que lo atiende ni un empleado del médico que lo atiende. Si el testigo es empleado del centro de salud en el cual se cuida al paciente, este testigo no puede estar directamente involucrado en el suministro de atención al paciente. Este testigo no puede ser funcionario, director, socio o empleado de la oficina del centro de atención médica donde se atiende al paciente o de ninguna organización matriz del centro de atención médica.

Testigo (1)____________________________________

Testigo (2)____________________________________

Definiciones:

"Nutrición e hidratación artificial" quiere decir el suministro de nutrientes o líquidos mediante una sonda puesta en una vena, bajo la piel en los tejidos subcutáneos o en el estómago (tracto gastrointestinal).

"Padecimiento irreversible" quiere decir un padecimiento, lesión o enfermedad:

a. que se puede tratar, pero que nunca sana;

b. que deja a la persona incapaz de cuidarse o tomar decisiones por ella misma, y

c. que sin el tratamiento para prolongar la vida, suministrado conforme con las normas actuales de atención médica, podría ser fatal.

Explicación: muchas enfermedades graves como el cáncer, la insuficiencia de cualquier órgano vital (el riñón, el corazón, el hígado o el pulmón) y una enfermedad del cerebro grave, como la demencia de Alzheimer, se pueden considerar irreversibles desde muy temprano. No hay curación, pero el paciente puede mantenerse con vida por periodos prolongados de tiempo si recibe tratamientos para prolongar la vida. Más tarde durante la misma enfermedad, ésta se puede considerar terminal cuando, incluso con tratamiento, se espera que el paciente muera. Usted deberá considerar qué niveles de tratamiento está dispuesto a soportar para lograr un resultado particular. Ésta es una decisión muy personal que usted deberá discutir con el doctor, la familia u otras personas importantes en su vida.

*Tratamiento para prolongar la vida* quiere decir un tratamiento que, a juicio médico, preserva la vida de un paciente y sin el cual el paciente moriría. El término se refiere a medicamentos para preservar la vida y a medios artificiales para mantener la vida como los respiradores mecánicos, el tratamiento de diálisis del riñón, la hidratación y la nutrición artificial. El término no se refiere a la administración de medicamentos para el dolor, la ejecución de un procedimiento quirúrgico necesario para suministrar comodidad ni ningún otro servicio médico ofrecido para aliviar el dolor del paciente.

"Padecimiento terminal" quiere decir una enfermedad incurable causada por lesión, enfermedad o dolencia que a juicio médico produciría la muerte dentro de unos seis meses, incluso con el tratamiento disponible para prolongar la vida suministrado de acuerdo con las normas de atención médica actuales.

Explicación: muchas enfermedades graves se pueden considerar irreversibles desde muy temprano en la evolución de la enfermedad, pero no se considera terminal hasta que la enfermedad ha avanzado bastante. Al pensar en una enfermedad terminal y su tratamiento, deberá considerar los beneficios y las dificultades relacionados con el tratamiento y discutirlos con el doctor, la familia u otras personas importantes en su vida.
OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER
TEXAS DEPARTMENT OF STATE HEALTH SERVICES

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name

<table>
<thead>
<tr>
<th>Person's signature</th>
<th>Date</th>
<th>Printed name</th>
</tr>
</thead>
</table>

A. Declaration of the adult person: I am competent and at least 18 years of age. I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

<table>
<thead>
<tr>
<th>Person's signature</th>
<th>Date</th>
<th>Printed name</th>
</tr>
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</table>

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

- I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

- Based upon the known desires of the person, or a determination of the best interest of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

<table>
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<tr>
<th>Signature</th>
<th>Date</th>
<th>Printed name</th>
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</table>

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

- ☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

- To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication.

- I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

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<th>Signature</th>
<th>Date</th>
<th>Printed name</th>
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</table>

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person:

- I am the above-noted person's attending physician and have:

  - ☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR  ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

- I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

<table>
<thead>
<tr>
<th>Attending physician's signature</th>
<th>Date</th>
<th>Printed name</th>
</tr>
</thead>
</table>

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

- A physician has diagnosed the minor as suffering from a terminal or irreversible condition.

- I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

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<th>Signature</th>
<th>Date</th>
<th>Printed name</th>
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</table>

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

<table>
<thead>
<tr>
<th>Witness 1 signature</th>
<th>Date</th>
<th>Printed name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Witness 2 signature</th>
<th>Date</th>
<th>Printed name</th>
</tr>
</thead>
</table>

Notary in the State of Texas and County of . The above noted person personally appeared before me and signed the above noted declaration on this date: .

<table>
<thead>
<tr>
<th>Signature &amp; seal: Notary's printed name:</th>
<th>Notary Seal</th>
</tr>
</thead>
</table>

[ Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner ]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

<table>
<thead>
<tr>
<th>Physician's signature</th>
<th>Date</th>
<th>License #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of second physician</th>
<th>Date</th>
<th>Lic#</th>
</tr>
</thead>
</table>

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

<table>
<thead>
<tr>
<th>Person's signature</th>
<th>Guardian/Agent/Proxy/Relative signature</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Attending physician's signature</th>
<th>Second physician's signature</th>
<th>Notary's signature</th>
</tr>
</thead>
</table>

This document or a copy thereof must accompany the person during his/her medical transport.
INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER

PURPOSE: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care.

APPLICABILITY: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.

IMPLEMENTATION: A competent adult person, at least 18 years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:

Section A - If an adult person is competent and at least 18 years of age, he/she will sign and date the Order in Section A.

Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B.

Section C - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C.

Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.

Section E - If the person is a minor (less than 18 years of age), who has been diagnosed by a physician as suffering from a terminal or irreversible condition, the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E.

Section F - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is not a representative of the ethics or medical committee of the health care facility in which the person is a patient.

In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section.

Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

REVOCATION: An OOH-DNR Order may be revoked at ANY time by the person, person's authorized representative, or physician who executed the order. Revocation can be by verbal communication to responding health care professionals, destruction of the OOH-DNR Order, or removal of all OOH-DNR identification devices from the person.

AUTOMATIC REVOCATION: An OOH-DNR Order is automatically revoked for a person known to be pregnant or in the case of unnatural or suspicious circumstances.

DEFINITIONS

Attending Physician: A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state, [HSC §166.002(12)].

Health Care Professional: Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. [HSC §166.081(5)]

Qualified Relative: A person meeting requirements of HSC §166.088. It states that an adult relative may execute an OOH-DNR Order on behalf of an adult person who has not executed or issued an OOH-DNR Order and is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, and the relative is available from one of the categories in the following priority: 1) person's spouse; 2) person's reasonably available adult children; 3) the person's parents; or, 4) the person's nearest living relative. Such qualified relative may execute an OOH-DNR Order on such described person's behalf.

Qualified Witnesses: Both witnesses must be competent adults, who have witnessed the competent adult person making his/her signature in section A, or person's authorized representatives making his/her signature in either Sections B, C, or E on the OOH-DNR Order, or if applicable, have witnessed the competent adult person making an OOH-DNR by nonwritten communication to the attending physician, who signs in Section D. Optionally, a competent adult person, guardian, agent, proxy, or qualified relative may sign the OOH-DNR Order in the presence of a notary instead of two qualified witnesses. Witness or notary signatures are not required when two physicians execute the order by signing Section F. One of the witnesses must meet the qualifications in HSC §166.003(2), which requires that at least one of the witnesses not: (1) be designated by the person to make a treatment decision; (2) be related to the person by blood or marriage; (3) be entitled to any part of the person's estate after the person's death under a will or by law; (4) have a claim at the time of the issuance of the OOH-DNR against any part of the person's estate after the person's death; or, (5) be the attending physician; (6) be an employee of the attending physician or (7) an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the patient or is an officer, director, partner, or business office employee of the health care facility or any parent organization of the health care facility.

Report problems with this form to the Texas Department of State Health Services (DSSH) or order OOH-DNR Order/forms or identification devices at (512) 834-6700.

Declartant's, Witness', Notary's, or Physician's electronic or digital signature must meet criteria outlined in HSC §166.011

Publications No. EF01-11421 - Revised July 1, 2009 by the Texas Department of State Health Services
Disclosure Statement for Medical Power of Attorney
Advance Directives Act (see §166.163, Health and Safety Code)

This is an important legal document. Before signing this document, you should know these important facts:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.
Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

This Power of Attorney is not valid unless it is signed in the presence of two competent adult witnesses. The following persons may not act as ONE of the witnesses:

- the person you have designated as your agent.
- a person related to you by blood or marriage;
- a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- your attending physician;
- an employee of your attending physician;
- an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of a health care facility or of any parent organization of the health care facility; or
- a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.
Designation of Health Care Agent:

I, ________________________________ (insert your name) appoint:

Name: ________________________________
Address: ________________________________
Phone: _____________________________

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

Limitations On The Decision Making Authority Of My Agent Are As Follows:

________________________________________
________________________________________
________________________________________

Designation of an Alternate Agent:

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s), to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent
Name: ________________________________
Address: ________________________________
Phone: _____________________________

Second Alternate Agent
Name: ________________________________
Address: ________________________________
Phone: _____________________________

The original of the document is kept at ________________________________

________________________________________

The following individuals or institutions have signed copies:

Name: ________________________________
Address: ________________________________

Name: ________________________________
Address: ________________________________

Name: ________________________________
Address: ________________________________

(continued on reverse)
Duration
I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(If Applicable) This power of attorney ends on the following date: ______________________

Prior Designations Revoked
I revoke any prior medical power of attorney.

Acknowledgement of Disclosure Statement
I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in this disclosure statement.

(You Must Date and Sign This Power of Attorney)
I sign my name to this medical power of attorney on _____ day of ______________ (month, year) at

__________________________________________
(City and State)

__________________________________________
(Signature)

__________________________________________
(Print Name)

Statement of First Witness
I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: __________________________________________
Print Name: __________________________________________ Date: ______________
Address: ____________________________________________

__________________________________________
Signature of Second Witness
Signature: __________________________________________
Print Name: __________________________________________ Date: ______________
Address: ____________________________________________
Declaración referente al poder médico
Ley de Directivas Anticipadas (ver §166.163, del Código de Salud y Seguridad)

Éste es un documento legal importante. Antes de firmar este documento debe saber esta información importante:

Salvo los límites que usted imponga, este documento le da a la persona que usted nombre como su agente la autoridad de tomar, en su nombre, y cuando usted ya no esté en capacidad de tomarlas por su propia cuenta, todas y cada una de las decisiones referentes a la atención médica conforme con sus deseos y teniendo en cuenta sus creencias morales y religiosas. Puesto que "atención médica" se refiere a cualquier tratamiento, servicio o procedimiento para controlar, diagnosticar o tratar cualquier padecimiento físico o mental, su agente tiene el poder de tomar, en su nombre, decisiones sobre una amplia gama de opciones médicas. Su agente puede dar consentimiento, negar consentimiento o retirar el consentimiento para recibir tratamiento médico y puede decidir si suspender o no dar tratamiento para prolongar la vida. Su agente no puede autorizar su ingreso voluntario a un hospital para recibir servicios de salud mental, ni que le den tratamiento convulsivo, psicocirugía o un aborto. El doctor deberá seguir las instrucciones de su agente o permitir que se le cambie a usted de doctor.

La autoridad de su agente comenzará cuando su doctor certifique que usted no está en capacidad de tomar decisiones de carácter médico.

Su agente tiene la obligación de seguir sus instrucciones cuando tome decisiones en su nombre. A menos que usted especifique lo contrario, su agente tiene la misma autoridad que usted tendría para tomar decisiones sobre su atención médica.

Antes de firmar este documento, es muy importante que hable sobre éste con el doctor o con cualquier proveedor médico para asegurarse de que entienda la naturaleza y los límites de las decisiones que se tomarán en su nombre. Si no tiene un doctor, debe hablar con alguien más que sepa de estos asuntos y pueda contestar sus preguntas. No necesita la ayuda de un abogado para hacer este documento, pero si hay algo en este documento que usted no entienda, debe pedirle a un abogado que se lo explique.

La persona que usted nombre como su agente debe ser alguien conocido y de su confianza. Debe ser mayor de 18 años, o puede ser menor de 18 años si se le ha retirado la incapacidad de minoría de edad. Si usted nombra al proveedor de atención médica o terapeuta (por ejemplo, su doctor o un empleado del centro de salud, hospital, casa para convalecientes o centro de tratamiento terapéutico, que no sea un pariente) esa persona tiene que escoger entre ser su agente o ser su proveedor de atención médica o terapeuta; conforme con la ley, una misma persona no puede desempeñar las dos funciones a la vez.

Debe informarle a la persona que usted escoja que quiere que ella sea su agente de atención médica. Usted debe hablar sobre este documento con su agente y con su doctor y darle a cada uno de ellos una copia firmada. Usted debe escribir en el documento el nombre de las personas e instituciones a quienes ha dado copias firmadas. Su agente no puede ser enjuiciado por las decisiones sobre atención médica tomadas de buena fe en su nombre.

Aun después de firmar este documento, usted tiene el derecho de tomar decisiones de atención médica mientras esté en capacidad de hacerlo y no se le puede administrar o detener un tratamiento si usted se opone. Tiene derecho de revocar la autoridad otorgada a su agente informándole a su agente o a su proveedor de atención médica o terapeuta, oralmente o por
escrito, y firmando un nuevo poder médico. A menos que indique lo contrario, el nombramiento de su cónyuge como su agente se disuelve en el caso de que usted se divorcie.

Este documento no se puede modificar o cambiar. Si quiere hacer algún cambio, tiene que hacer un documento nuevo.

Es aconsejable que nombre a un tercer agente en caso de que su agente no quiera, no pueda o esté incapacitado para actuar como su agente. Cualquier agente alterno que usted nombre tendrá la misma autoridad de tomar decisiones de atención médica en su nombre.

Este poder no tiene validez a menos que se firme en presencia de dos testigos adultos hábiles.

Las siguientes personas no pueden actuar como UNO de los testigos:

- la persona que usted ha nombrado como su agente;
- una persona que es su pariente por sangre o matrimonio;
- una persona que, después de su muerte, tenga derecho a cualquier porción de su sucesión de acuerdo con su testamento o con una adición a su testamento firmado por usted o que tenga derecho a ésta por efecto legal;
- el doctor que lo atiende;
- un empleado del doctor que lo atiende;
- un empleado de un centro de atención médica del cual usted es paciente si el empleado le está prestando servicios directamente a usted o es un funcionario, director, socio o empleado de las oficinas del centro de atención médica o de cualquier organización matriz del centro de atención médica; o
- una persona que, en el momento de firmar este poder, pueda reclamar cualquier porción de su sucesión después de su muerte.
Poder médico
Ley de Directivas Anticipadas (ver §166. 164, del Código de Salud y Seguridad)

Nombramiento de un agente de atención médica:

Yo, ________________________________________________ (escriba su nombre) nombro a:
Nombre:_____________________________________________________________________
Dirección:_____________________________________________________________________
_____________________________________________________________________________
Teléfono: __________________________

como mi agente para que tome todas y cada una de las decisiones sobre atención médica por mí,
a menos que yo diga lo contrario en este documento. Este poder médico entra en vigor si yo no
tengo capacidad para tomar mis propias decisiones sobre la atención médica y mi doctor certifica
este hecho por escrito.

La autoridad de mi agente médico para tomar decisiones tendrá las siguientes limitaciones:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Nombramiento de un agente alterno:

(Usted no tiene que nombrar a un agente alterno, pero si quiere puede hacerlo. Un agente alterno
puede tomar las mismas decisiones médicas que tomaría el agente designado si el agente
designado no puede o no quiere hacer las veces de agente. Si el agente designado es su
cónyuge, el nombramiento se revoca automáticamente por ley si su matrimonio se disuelve).

Si la persona designada como mi agente no es capaz o no está dispuesta a tomar decisiones
médicas por mí, nombro a las siguientes personas, para que hagan las veces de agente para
tomar decisiones de tipo médico conforme yo las autorice por medio de este documento. Lo harán
en el siguiente orden:

Primer Agente Alterno
Nombre:_____________________________________________________________________
Dirección:_____________________________________________________________________
_____________________________________________________________________________
Teléfono: __________________________

Segundo Agente Alterno
Nombre:_____________________________________________________________________
Dirección:_____________________________________________________________________
_____________________________________________________________________________
Teléfono: __________________________
El original de este documento se mantendrá en:
____________________________________________________________________________

Las siguientes personas o instituciones tienen copias firmadas:
Nombre:__________________________________________________________
Dirección:______________________________________________________________________

Nombre:__________________________________________________________
Dirección:______________________________________________________________________

Nombre:__________________________________________________________
Dirección:______________________________________________________________________

**Duración**
Comprendo que este poder existirá indefinidamente a partir de la fecha en que se firma el documento a menos que yo establezca un término más corto o lo revoque. Si no estoy en capacidad de tomar decisiones médicas por mi propia cuenta cuando este poder se venza, la autoridad que le he dado a mi agente seguirá en vigor hasta que yo pueda volver a tomar decisiones por mí mismo.
(Si aplica) Este poder se vencerá en la siguiente fecha: _______________________________

**Revocación de nombramientos anteriores**
Revoco cualquier poder médico anterior.

**Acuse de recibo de la Declaración**
Me dieron la declaración en la que se explica las consecuencias de este documento. La leí y la entiendo.

(Tiene que escribir la fecha y firmar este poder)

Firmo mi nombre en este poder médico el ________ de __________________ (mes) de ______ (año) en
______________________________________________________________________
(Ciudad y Estado)

(Firma)
________________________________________________________________________
(Nombre en letra de molde)

**Declaración del primer testigo**
No soy la persona designada como agente por medio de este documento. No soy pariente del poderante ni por sangre ni por matrimonio. No tendré derecho a ninguna parte de la sucesión del poderante después de su fallecimiento. No soy el médico tratante del poderante ni estoy empleado por el médico tratante. No tengo ningún derecho sobre ninguna porción de la sucesión del poderante después de su fallecimiento. Además, si trabajo en el centro de atención médica
donde es paciente el poderante, no tengo que ver con el cuidado directo del poderante y no soy funcionario, director, socio, ni empleado de la oficina del centro de atención médica ni de ninguna organización matriz del centro de atención médica.

Firma:_________________________________________________________________________

Nombre en letra de molde:__________________________ Fecha: ____________

Dirección:________________________________________________________________________

**Firma del segundo testigo**

Firma:_________________________________________________________________________

Nombre en letra de molde:__________________________ Fecha: ____________

Dirección:________________________________________________________________________

versión 10/25/99
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Cigna- HealthSpring has adopted evidence based clinical practice guidelines as roadmaps for healthcare decision-making targeting specific clinical circumstances. Cigna-HealthSpring promotes the use of clinical practice guidelines to:

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

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

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<td>2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults Primary Care Management of Chronic Stable Angina and Asymptomatic Suspected or Known Coronary Artery Disease: Ann Intern Med. 5 October 2004;141(7):562-567</td>
<td>American College of Cardiology <a href="http://circ.ahajournals.org/content/119/14/e391.full.pdf">http://circ.ahajournals.org/content/119/14/e391.full.pdf</a> American College of Physicians <a href="http://annals.org/article.aspx?volume=141&amp;issue=7&amp;page=562">http://annals.org/article.aspx?volume=141&amp;issue=7&amp;page=562</a></td>
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Approved by Clinical Guideline Steering Committee January 2014
Antithrombotic Therapy and Prevention of Thrombosis guideline adopted June 9, 2014
This information is provided for general reference and not intended to address every clinical situation associated with the conditions and diseases addressed by these guidelines. Physicians and health care professionals must exercise clinical discretion in interpreting and applying this information to individual patients. We hope you will consider this information and use it, when it is appropriate for your eligible members.