Cigna LifeSOURCE Network for Transplants and Advanced Cellular Therapies

Provider Reference Guide

February 2026

cigna healthcare

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Introduction

Our commitment and mission

We are committed to working with health care providers to ensure that our customers have access to quality services and benefits. That means working with you across all the aspects of today's health care world.

The Cigna LifeSOURCE Network is a specialized component of Cigna Healthcare® that offers access to high-performing transplant and Advanced Cellular Therapy (ACT) providers with an enhanced benefit for our customers. The network is dedicated to managing and providing access to complex medical services with the goal of reducing costs; reducing or eliminating unnecessary procedures; maintaining or improving the quality of transplant procedures; and improving the overall transplant experience for our customers and their families.

The Cigna LifeSOURCE Network focuses on high-quality providers to service our customers and their families, which includes:

- A national quality program.
- A comprehensive dedicated transplant case management team.
- Coverage positions.
- Specially trained claims personnel.
- Dedicated contracting, medical directors, and clinical staff.
- Travel benefits, when applicable.

The Cigna LifeSOURCE team is made up of dedicated health care and transplant professionals who work to uphold and improve all aspects of the Cigna LifeSOURCE Network.

Inside the guide

To help us stay on the same page, we have created this reference guide for you. It highlights the procedures and policies intended to keep our relationship smooth and productive — for the sake of the people we serve together.

This reference guide includes Administrative Guidelines and Program Requirements for the programs, policies, and procedures pertaining to Cigna Healthcare insured or administered benefit plans, such as information regarding case management, clinical documentation, network program inclusion requirements, contacts, claims, and terminology. We will give you advance notice of any material changes to our Administrative Guidelines and Program Requirements.

Your Cigna LifeSOURCE Participation Agreement ("Agreement") and this reference guide describe many of the terms under which you agree to provide services to our customers. Those terms include the reimbursement rates applicable to covered services provided to our customers. However, the actual benefits payable by a payor for covered services provided to a customer in all cases is determined by the terms of the payor's benefit plan.

We hope this guide helps you as we work together to ensure our customers receive quality and affordable transplant and advanced cellular care.

Notes

State law may supersede the information provided in this guide. For state-specific information, please check your Agreement or log in to the Cigna for Health Care Professionals website (**CignaforHCP.com**).

Provider participation

In order to participate in the Cigna LifeSOURCE Network, you must be contracted with the local market for medical services.

As part of your Agreement with Cigna LifeSOURCE, you agree to refer your patients with Cigna Healthcare® coverage to other in-network providers, hospitals, and facilities. Naturally, there are some exceptions, for example, in an emergency or if services cannot be provided within the network. However, we have made significant investments in online tools, smartphone apps, and customer service to help your patients make informed decisions about their care and costs so they can "know before they owe." We expect that you will partner with Cigna LifeSOURCE patients to help them maximize their benefits by referring additional care to other in-network providers.

As a Cigna LifeSOURCE–participating provider, you must provide services with the same standard of care, skill, and diligence customarily used by similar providers in your community; follow the requirements of applicable law; and meet the standards of applicable accreditation organizations. All services that are provided within the scope of your practice or license must be provided on an in-network basis. You are expected to provide services to Cigna LifeSOURCE patients in the same manner, under the same standards, and with the same time availability (i.e., wait time for an appointment) as offered to other patients. You will not differentiate or discriminate in the treatment of any Cigna LifeSOURCE patient based on race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, veteran's status, handicap, or source of payment.

Further, as an in-network provider, you must meet our credentialing standards for training, licensure, and performance before joining the network. You will also be evaluated periodically to help ensure continued qualification. Performance requirements include providing quality services to patients and cooperating with Cigna LifeSOURCE administrative, quality, and case management programs. We evaluate performance data for quality improvement activities, preferred status designation in our network, and reduced customer cost-sharing, as applicable.

Facility termination and termination activities

If your participation with Cigna Healthcare® is terminated entirely, your LifeSOURCE Participation Agreement will also terminate in accordance with your contractual notice period.

Cigna LifeSOURCE shall engage in termination activities, such as providing patients with advance notification of the possible termination, reflecting a future termination date in the provider directory, and discontinuing referrals to Hospital and Represented Providers during the notice period.

Cigna LifeSOURCE will notify affected patients of the termination to the extent required by applicable law and accrediting requirements. Such notification will occur before the effective date of the termination unless Cigna LifeSOURCE does not receive sufficient advance notice. In this instance, Cigna LifeSOURCE will notify affected patients to the extent required as soon as reasonably possible. Upon request, you are responsible for providing a listing of patients affected by your termination within seven business days of the date of the notice of termination.

In the event you decide to send any written communication to patients regarding your Cigna LifeSOURCE participation or use our name in such manner, we reserve the right to review and approve the communication prior to release. You may not make any disparaging comments about Cigna Healthcare or misrepresentations in any communications regarding your participation with Cigna LifeSOURCE. Refer to your Agreement for more information.

Office hours and accessibility

Hospital and Represented Providers must provide or arrange for necessary medical services 24 hours a day, seven days a week.

There must be a publicized telephone number for patients to call and telephone calls must be answered promptly by a person trained in the appropriate response to medical calls of a routine, urgent, or emergent nature.

Cooperation with programs

Cigna LifeSOURCE is committed to promoting access to quality services for your patients with Cigna Healthcare® coverage. To support this commitment, we require your cooperation with Cigna LifeSOURCE programs, including administrative (e.g., appeals), quality, and case management programs. We also require your cooperation with Cigna LifeSOURCE in establishing and implementing policies and programs to comply with regulatory, contractual, and accreditation requirements.

Patient billing

Copay: A Copay is a fixed dollar amount that a patient pays per service. Copay amounts are printed on the Cigna Healthcare® ID card and should be collected at the time of service.

Coinsurance and Deductible: A Deductible is the amount a patient pays each year for eligible medical services or medications before their health plan begins to share in the cost of covered services. Coinsurance is the percentage of covered charges that the patient pays for after they have satisfied their Deductible. For patients with plans that have a Deductible or Coinsurance, you should submit claims to Cigna LifeSOURCE or its designee and receive an explanation of payment (EOP) indicating the patient responsibility before billing patients. Coinsurance and Deductible amounts should not be collected at the time of service.

Denied payment and patient nonliability

You cannot bill your patients with Cigna Healthcare® coverage for covered services or for services for which payment was denied due to your failure to comply with your Agreement or Administrative Guidelines and Program Requirements, including Cigna LifeSOURCE utilization/case management requirements and timely filing requirements.

Confidentiality

We maintain strict policies to protect confidential information. As an in-network provider, you are responsible for maintaining the confidentiality of patient information in all settings in accordance with federal and state laws. Written policies and procedures should be established that include the designation, maintenance, release, and control of access to confidential records.

If you have questions or comments about our policies, please call us at **800.88Cigna (882.4462)**.

Medical records

We safeguard patient information and expect the same standard of you. To maintain confidentiality and privacy of protected health information (PHI) and personally identifiable information (PII), you must keep secure, accurate, and organized medical records for each patient with Cigna Healthcare® coverage and comply with applicable federal and state law about such records.

You must allow our personnel access to patient medical records, including medical chart reviews, as appropriate for business purposes during normal business hours. For electronic medical record access, if you require Cigna Healthcare, its employees, and/or its designee to execute a data access or data use agreement, the following shall apply and supersede any conflicting terms or conditions within such agreements:

1. Cigna Healthcare employees and/or its designee may not be held individually liable by a provider for any act, omission, or breach of such agreements, absent any willful and wanton or criminal conduct.
2. Cigna Healthcare and/or its designee are only obligated to comply with those terms and conditions applicable to it as a payor or consistent with the access necessary to fulfill Cigna Healthcare duties and obligations under the terms and conditions of your Agreement with Cigna Healthcare.

3. In the event of a conflict between the parties' policies and procedures, Cigna Healthcare policies and procedures shall control with regards to its obligations.
4. As both parties are Health Insurance Portability and Accountability Act of 1996–covered entities (HIPAA-covered entities), your data access or use agreement shall not be construed to create a business associate relationship with Cigna Healthcare and/or its designee.
5. Cigna Healthcare and/or its designee shall not be liable for any breach of data not otherwise attributable to the negligence of Cigna Healthcare, its employees, or its designee.

At the time of service, you must request that patients sign a routine consent form allowing for the disclosures required under the Agreement and these Administrative Guidelines and Program Requirements to the extent such consent or approval is required by law.

Excluded services

Excluded services are those that are:

- Rendered at facilities not included in the Agreement.
- Not included in a case rate that Cigna LifeSOURCE has elected to obtain under an arrangement between Cigna Healthcare®, a Cigna Healthcare affiliate, or a national or regional vendor.

To add facilities or affiliated providers to an existing transplant program and Agreement:

- Providers must provide 90-day written notice prior to the desired effective date of the addition.
- Providers must complete the **New Provider Intake Form**.
- All satellite or affiliated providers must bill through the transplant provider Taxpayer Identification Number (TIN).
- The transplant program must have the authority to bind and represent the satellite or affiliated providers and, as applicable, provide payment to the Represented Providers.

Please refer to the **Quality information section** for additional details.

Unless otherwise agreed by Cigna Healthcare, you are encouraged to refer your patients, as clinically appropriate, to the national ancillary providers available to Cigna Healthcare customers as outlined in the **National Ancillaries section**.

Phases of care

Cigna LifeSOURCE Network includes specialized, dedicated transplant case managers who supervise services for transplants and Advanced Cellular Therapy (ACT) recipients through each phase of care. Cigna LifeSOURCE identifies the phases of care as "zones."

Note: Covered services not related to transplant and/or post-transplant service requests are subject to prior authorization and medical necessity review. Coverage and authorization requirements vary by benefit plan. Certain services may be redirected in accordance with the patient's specific benefit plan provisions.

Zone 1: Evaluation

Please call the Transplant Case Management team at 800.668.9682 to get prior authorization before you begin evaluation.

Zone 1 is the candidacy period. The transplant team evaluates the patient to determine if they are an acceptable candidate for a solid organ transplant, stem cell transplant, or Advanced Cellular Therapy (ACT).

This zone includes all diagnostic tests performed on the patient and a live donor, if applicable. A zone 1 authorization should be requested if Human Leukocyte Antigen (HLA) Typing for potential liver donors will be performed, as these services are part of the evaluation period. Please notify the transplant care manager if a living donor will be receiving testing. Zone 1 should also be requested if an unrelated search is conducted, as these services are also transplant services and only intended to be covered if a patient is actively pursuing a transplant.

The transplant center is expected to provide all diagnostic tests. These tests cannot be outsourced.

While some tests, such as colorectal testing and gynecological and dental exams, may seem less critical to transplant, they are required to ascertain the health status of Cigna LifeSOURCE patients facing transplant. If you are in doubt about required testing, please consult with the patient's case manager.

Unless otherwise stated in your Agreement, the zone begins when the patient starts the Cigna Healthcare–authorized evaluation. It ends on the date the patient is accepted into the hospital's transplant/ACT program or deemed not acceptable as a transplant/ACT candidate.

Zone 2: Pretransplant

Zone 2 is the pretransplant period that occurs after zone 1 and continues until the day prior to the transplant/Advanced Cellular Therapy (ACT) procedure or the beginning of the transplant/ACT event. Non-transplant-related care for the underlying disease condition is typically excluded from this zone. Please contact the Transplant Case Management team prior to listing the patient for a transplant to ensure that the correct authorizations are in place.

Solid organs

For solid organs, this zone includes transplant-related care only for routine surveillance of the recipient as needed to maintain their candidacy status. This includes any testing required to determine organ function, clinic visits, etc. Zone 2 does not include ongoing maintenance care, such as renal dialysis.

Bone marrow, stem cell, and cord blood transplants

Unless your Agreement for autologous bone marrow transplants/stem cell transplants (BMTs/SCTs) specifies otherwise, the beginning of this zone is represented by the acceptance of the patient into the hospital's transplant program.

For allogeneic BMTs/SCTs, the candidacy zone typically starts after the recipient has been accepted into the program and ends the day prior to the transplant event.

Note: Approval is only given for one year at a time. When a patient approaches one year in zone 2, the case manager will contact your transplant program to find out the status of the patient and to assess whether to extend zone 2 approval.

ACT

The zone 2 start and end dates are specific to the ACT:

- **Chimeric antigen receptor (CAR) T-cell and T-cell receptor (TCR) therapy:** Zone 2 typically starts after the recipient has been accepted into the CAR T-cell or TCR program and it ends the day prior to leukapheresis.
- **Tumor-infiltrating lymphocyte (TIL):** Zone 2 typically starts after the patient is accepted into the TIL program and includes, but is not limited to, tumor tissue procurement and cell storage. The end date is the day prior to lymphodepletion.

Zone 3: Transplant event

Zone 3 includes living donor services for up to 30 days after the date of donation.

All transplant-related services for the patient provided during this time are included in the zone 3 rate unless there is a specific exclusion referenced in your Agreement. Please refer to your specific Agreement for terms related to the management and treatment of the underlying disease.

The zone 3 start and end dates are specific to each transplant facility's Agreement. Please consult your Agreement to determine the exact end date.

- For solid organ transplants, zone 3 typically begins on the day of or the day prior to the transplant procedure and ends when the recipient is discharged from the hospital.
- For autologous and allogeneic-related bone marrow transplants/stem cell transplants (BMTs/SCTs), the transplant event zone typically begins with mobilization.
- For allogeneic-unrelated BMTs/SCTs and cord blood transplants, zone 3 typically begins with the onset of preparative regimen.
- For Advanced Cellular Therapy (ACT), your Agreement provides specific start and end dates.

Note: The infusion of stem cells, including donor cells performed as a "boost" to enhance cell recovery, is not considered a transplant and will be included in the zone 3 rate if performed during this period.

Zone 4: Post transplant follow-up

Zone 4 includes all transplant and Advanced Cellular Therapy (ACT) follow-up care for the recipient.

The time period typically included in this zone is one year for some solid organs and six months for stem cell therapy and ACT.

Your Agreement should be reviewed for the specific amount of time and the services included in this zone.

Quality information

For network participation consideration

For programs not currently in the network, facilities may contact their provider services representative or complete the form below to be evaluated. The provider services representative will work with the Quality department to begin the certification process.

989009 Lifesource Provider New Intake F

Adding facilities and affiliated transplant programs to Agreement

To add facilities or affiliated transplant programs to an existing transplant program and Agreement:

- Providers must provide 90-day written notice prior to the desired effective date of the addition.
- Providers must complete the **New Provider Intake Form**.
- All satellite or affiliated providers must bill through the transplant provider Taxpayer Identification Number (TIN).
- The transplant program must have the authority to bind and represent the satellite or affiliated providers and, as applicable, provide payment to the Represented Providers.

The quality director is responsible for notifying you of the outcome. If approved by quality and network management, the assigned contractor will generate an amendment to include the new satellite or affiliated providers.

Quality performance

The foundation of the Cigna LifeSOURCE Network is our quality performance program managed through the Network Performance Review Committee (NPRC).

Each Cigna LifeSOURCE program is carefully chosen to participate in the Cigna LifeSOURCE Network and must continue to meet our established quality standards.

Our transplant programs are approved at one of the following levels of participation:

- **Designated:** To be approved to be in our top tier, each solid organ transplant program is reviewed. We assess both the combined deceased and living donor transplant rate and combined deceased and living donor one-year graft hazard ratio to determine that the program performance meets our customers' and business needs. All programs must maintain minimum volumes, waitlist transplant rate, patient and graft survival outcomes, and accreditations to be listed as designated.

  Allogeneic bone marrow transplant/stem cell transplant (BMT/SCT) programs must also meet or exceed the predicted values on the annual Center for International Blood and Marrow Transplant Research (CIBMTR) Center Specific Survival report. Autologous programs must continue to meet minimum designated-level volume requirements.

  Designation status is also subject to a market cost review to confirm the rates for each program are competitively priced relative to equivalent programs in the region or market. Please note, not every transplant program at a Cigna LifeSOURCE–participating facility may meet all the designated minimum guidelines at a given time.
- **Supplemental:** Programs not meeting the designated level are eligible for consideration as a supplemental program, which is our second tier. This solution provides access to certain transplant programs outside of the designated level. Supplemental programs do not meet the stringent designated-level standards of transplant outcomes and/or market cost review, but they must achieve

and maintain the Centers for Medicare & Medicaid Services (CMS) certification for solid organs and the Foundation for the Accreditation of Cellular Therapy (FACT) and National Marrow Donor Program (NMDP) accreditation for bone marrow transplants/stem cell transplants (BMTs/SCTs). In the event the certifications or accreditations are in jeopardy or have been suspended for any reason, the program may lose its participation level status and will no longer be a participating program in the Cigna LifeSOURCE Network.

The quality process is essential in ensuring program performance and providing our customers with access to excellence in transplant and Advanced Cellular Therapy (ACT) care. Each transplant program under network consideration begins the quality process by completing a request for information (RFI). The Cigna LifeSOURCE Network uses the United Network for Organ Sharing standardized RFI form for all solid organ transplant procedures and the American Society for Transplantation and Cellular Therapy standardized RFI form for all BMT/SCT procedures to support consistency in the process.

The RFI provides program-specific data that is evaluated against the **Cigna LifeSOURCE network inclusion guidelines for transplants and advanced cellular therapies** for each therapy type. Critical components evaluated in the RFI include, but are not limited to:

- Annual volumes of transplant procedures.
- Patient survival.
- Graft survival.
- Transplant wait time.
- Facility support.
- Team stability.
- Team training and experience.
- Quality improvement program.
- Protocols (patient selection, pre- and post-transplant management).
- Patient safety.
- Communication systems.

Guidelines for network inclusion

Cigna LifeSOURCE annually evaluates each transplant program to determine continued compliance with established guidelines.

The following accreditations and requirements must be met prior to network consideration:

- The program must participate with Cigna Healthcare®.
- The program must maintain hospital accreditation (e.g., Joint Commission of Hospital Accreditation or the National Integrated Accreditation for Healthcare Organizations by DNV Healthcare).
- Solid organ programs must maintain Centers for Medicare & Medicaid Services (CMS) certification (Hospital Conditions of Participation: Requirements for Approval and Re-Approval of Transplant Centers to Perform Organ Transplants).
- Bone marrow transplant (BMT) programs must have accreditation from the Foundation for the Accreditation of Cellular Therapy (FACT). Allogenic BMT programs must also secure approval by the National Marrow Donor Program (NMDP) as a transplant center and report volume and performance data into the Center for International Blood and Marrow Transplant Research (CIBMTR).

Listing at the designated level is also dependent on a market check to confirm the rates for each program are competitively priced relative to equivalent programs in the region or market.

Solid organ programs

Annual designated-level volume guidelines

The volumes in the table below apply to adult programs. Pediatric programs must demonstrate a functionally active program, performing at least one transplant in 12 consecutive months.

Transplant program	Minimum volume
Heart	12
Lung	12
Liver	12[1]
Kidney	30[2]
Intestinal	Three
Pancreas transplant alone (PTA), pancreas after kidney (PAK), and simultaneous pancreas kidney (SPK)[3]	Not applicable; kidney program must be approved

1. Twelve total combined deceased and living donors. Living liver programs must demonstrate active, ongoing live donor transplants annually.
2. Thirty total combined deceased and living donors. Kidney-only transplant centers are considered on a case-by-case basis only.
3. Transplant center must have an active pancreas and kidney-pancreas transplant program.

Performance guidelines

Adult programs must meet certain guidelines depending on the level:

- Designated-level programs must have three years of risk-adjusted performance data published in the Scientific Registry of Transplant Recipients (SRTR) and continue to meet the annual program volumes, as outlined in the table in the annual designated-level volume guidelines section. The combined deceased and living donor transplant rate and combined deceased and living donor one-year graft hazard ratio are used to determine the program performance.
- Supplemental-level programs must have one year of risk-adjusted performance data published by the SRTR.

Pediatric programs must demonstrate performance outcomes in the current SRTR program-specific reports (PSRs) and have active membership and leadership with the Organ Procurement and Transplantation Network (OPTN).

Bone marrow transplant/stem cell transplant programs

Annual designated-level volume guidelines

- Adult autologous programs must perform a minimum of 30 transplants per calendar year. Adult allogeneic programs must continue to perform transplants annually.
- Pediatric programs must perform 15 total transplants, combined autologous and allogeneic per calendar year.

Performance guidelines

All adult and pediatric bone marrow transplant/stem cell transplant (BMT/SCT) programs must achieve and maintain FACT accreditation for hematopoietic stem cell therapy and allogeneic BMT programs must be NMDP accredited as a transplant center and participate with CIBMTR.

The following are additional guidelines:

- Programs must be listed as "performing as predicted" (0) or "overperforming" (+1) on the current CIBMTR Center Specific Survival report to be considered designated. Designated-level programs subsequently listed as "underperforming" (-1) for ONE year will move to the supplemental level.
- Designated-level programs must demonstrate actual overpredicted survival ratios (actual/predicted) equal to or better than 0.90.
- In addition to the certifications required, adult and pediatric BMT/SCT programs must demonstrate active program volumes each year. Supplemental-level programs are listed as "underperforming" (-1) on the current CIBMTR Center Specific Survival report.

Additional network program requirements

- All new facility transplant programs approved for the designated level must agree to a site visit if a visit is requested.
- All network transplant programs must participate in the annual survey. Programs that do not respond may be subject to administrative action under the terms of their Agreement with Cigna Healthcare®. This may include shifting the programs from the designated to supplemental level.
- Solid organ transplant programs with live donor programs must continue to demonstrate ongoing live donor transplants on a yearly basis to be included as a live donor program.
- Designated- and supplemental-level programs must permit patients with Cigna Healthcare coverage to have multiple listings.
- Programs that are at risk of losing accreditations or certifications will be removed from the network program listings.
- All Advanced Cellular Therapy (ACT) programs, including bone marrow transplant/stem cell transplant (BMT/SCT), chimeric antigen receptor (CAR) T-cell therapy, T-cell receptor (TCR) therapy, tumor-infiltrating lymphocyte (TIL) therapy, and any novel cellular therapy programs, must obtain and maintain Foundation for the Accreditation of Cellular Therapy (FACT) accreditation for, as applicable, hematopoietic stem cell therapy and immune effector cell therapy. All Cigna Healthcare network providers servicing post-infusion cellular therapy patients for emergent care, such as adverse events or complications, must be specialized in oncology/hematology and achieve FACT accreditation for hematopoietic stem cell therapy and immune effector cell therapy.
- Immune effector cell therapy (specifically CAR T-cell therapy) stand-alone programs must obtain FACT accreditation for immune effector cell therapy, report performance data to the Center for International Blood and Marrow Transplant Research (CIBMTR) and assess rules for stem cell therapy options before initiating CAR T-cell therapy. The associated BMT/SCT program must be an in-network facility in the Cigna LifeSOURCE Network.
- Heart transplant programs must participate in the Cigna LifeSOURCE Network for the ventricular assist device (VAD) program to be included. The VAD program must obtain and maintain Centers for Medicare & Medicaid Services (CMS) certification for destination therapy and hold accreditation by The Joint Commission or DNV Healthcare.

For additional information on the network guidelines or relative performance index (RPI) methodology, please view the **Cigna LifeSOURCE network inclusion guidelines for transplants and advanced cellular therapies**.

Communicating staff and program changes

A Cigna Healthcare® quality director will ask annually if you have had any changes in your transplant staff or operation of your transplant program. It is important that you let us know when any changes happen. To do so, please email **LifeSOURCEProgramRequests@CignaHealthcare.com**. **Note:** This is a requirement of most Cigna LifeSOURCE Agreements.

Appeal information

If you are dissatisfied with our assessment of quality data, please submit an appeal in writing for reconsideration.

- Providers have 30 calendar days from the date of the survey results communication to submit a reconsideration request of the network-level decision. Requests received after the 30-day period will not be accepted. Providers can submit and attach the reconsideration request with the **Transplant Program Network Reconsideration Form**.
- Requests will be presented at the next meeting of the Network Performance Review Committee (NPRC). Providers will receive written notification of the results. Updated results will appear in the provider directory on the first of the month following the NPRC decision to change the network-level determination.

Cigna LifeSOURCE remains committed to continuing discussions with national transplant organizations and providers in the development of network inclusion guideline updates. Please note, network providers are independent providers and are not employees or agents of Cigna Healthcare®.

To help ensure the transplant program continues to provide quality, medically necessary, and cost-effective care, requests to add satellite or affiliated providers to an existing transplant program or Agreement are subject to the **Cigna LifeSOURCE network inclusion guidelines for transplants and advanced cellular therapies** and presented to the committee for approval.

Case management

Purpose

The Transplant Case Management Unit includes utilization management and case management services. It is designed to objectively monitor, evaluate, and positively influence the provision and cost of medical care for your patients referred for transplant and Advanced Cellular Therapy (ACT) case management services in accordance with the terms of their benefit plan.

Please call the transplant case manager assigned to your patient prior to providing any services.

Goals and objectives

The Transplant Case Management Unit's goal is to effectively use available health care resources to ensure and provide quality and appropriate care.

This is accomplished by:

- Consistently reviewing the medical necessity of procedures and treatments to determine the appropriate level of care and setting in which the care will be provided. This includes transplant- and Advanced Cellular Therapy–related (ACT-related) services and other nontransplant medical services required by a transplant patient while their case is "open."
- Providing and promoting access to appropriate and cost-effective health care services through appropriate referral to a Cigna LifeSOURCE facility; providing patient education; and facilitating communication and developing partnerships among patients, providers, and Cigna Healthcare® in an effort to enhance cooperation and appropriate use of health care services.
- Managing all transplant and ACT patients, especially those who are considered at risk of requiring extensive or ongoing health care services or of developing significant health care complications, and facilitating coordination and continuity of care to assist providers in achieving optimal medical outcomes.
- Delivering our services in a customer service–focused platform. This includes allowing reasonable access and providing timely communication of decisions made during the transplant case management process.
- Providing services in compliance with requirements of regulatory and accrediting bodies.
- Maintaining strict adherence to patient confidentiality.
- Partnering with the National Quality Review Council to identify and improve transplant services and provide effective monitoring and evaluation of patient care and services.
- Promptly identifying and analyzing opportunities to improve service level and implementing action and follow-up.
- Communicating quality-of-care concerns, as appropriate, to Cigna Healthcare or Cigna LifeSOURCE medical directors.

Managed services

The Transplant Case Management Unit manages services for customers where Cigna is the primary payer, including, but not limited to, the following:

- Advanced Cellular Therapy (ACT), such as chimeric antigen receptor (CAR) T-cell therapy and tumor-infiltrating lymphocyte (TIL) therapy.
- Solid organs, including multiple listing.
- Bone marrow transplants/stem cell transplants (BMTs/SCTs).
- Ventricular assist devices (VADs) and total artificial hearts (TAHs).
- Percutaneous ventricular assist devices (PVADs), such as TandemHeart® PTVA System, Impella 2.5®, Impella 5.0®, Impella 5.5® with SmartAssist®, Impella CP®, and Impella CP with SmartAssist.
    - PVADs are covered under Cigna Healthcare® medical coverage guidelines for short-term usage (e.g., bridge to recovery, hemodynamic support during high-risk cardiac procedures).

- PVADs are not reviewed or authorized through Cigna LifeSOURCE unless the patient is being followed by the Transplant Case Management team. Please contact the medical management team at **800.88Cigna (882.4462)** to obtain a PVAD authorization.

For copies of the clinical coverage guidelines and other resources used in making coverage determinations, visit the Cigna for Health Care Professionals website (**CignaforHCP.com**) or call us at **800.88Cigna (882.4462)**.

Please note that the Transplant Case Management Unit will not manage patients who have Medicare as their primary insurance due to end-stage renal disease or kidney transplant.

Contact information

The LifeSOURCE Case Management Transplant Unit is available via telephone and fax.

- **Telephone: 800.668.9682** (Monday through Friday from 8:00 a.m. to 6:00 p.m. ET).
  - If calling outside of business hours, follow the prompts to the appropriate confidential mailbox.
  - Calls regarding urgent requests will be returned within two hours. **Note:** All urgent requests require confirmation that the provider responsible has specifically stated that a determination is medically urgent.
  - Other calls will be returned within 24 to 48 hours.
- **Fax: 877.598.2484**.

The transplant case manager is your direct link to all prior authorizations for transplant and non-transplant-related services. Once your patient enters transplant case management, all services are handled by the assigned case manager for total patient care.

Examples of when the case manager should be contacted include, but are not limited to:

- Prior to the patient's transplant consultation.
- To obtain zone 1 evaluation testing approval.
- Prior to any movement between zones.
- Prior to listing for the transplant.
- Prior to any inpatient admission, whether the transplant is related or not.
- Prior to all specific tests, such as magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET) scans.
- Prior to scheduling any home health care, durable medical equipment (DME), or infusions (including intravenous immunoglobulin [IVIg]).
- To obtain prior authorization per benefit plan–specific requirements.

Frequent contact with the assigned case manager is vital in ensuring that all care is approved and authorized. If there is any question as to whether a service requires prior authorization, the assigned case manager will be able to accurately advise you. This partnership helps to provide the best care and coverage for your patients.

Multiple listings

Patients may choose to be listed at more than one facility for their transplant, subject to their plan language and benefit plan limitations.

Coverage for transplant services at any one time is available **only** at the primary transplant facility identified by the patient. Services covered at the primary transplant facility include all medically necessary transplant-related services and travel and lodging (if applicable).

The primary transplant facility is expected to share all appropriate clinical information with the additional facilities to evaluate the patient's acceptance for multiple listing. Cigna LifeSOURCE does not pay for duplicate testing (except for ABO Blood/Tissue Typing and Human Leukocyte Antigen [HLA] Typing) for transplant services at more than one facility at a time.

A consult authorization may be offered at the applicable medical benefit to a prospective multiple-listing transplant facility. The consult permits ABO Blood/Tissue Typing and HLA Typing per Organ Procurement and Transplantation Network (OPTN) guidelines and a provider visit to discuss their program and review evaluation records from the primary transplant facility with the patient. Lab work is permitted if it has been more than one year since labs were drawn at the primary transplant facility.

Coverage positions, clinical resource tools, and criteria

Coverage positions for all transplant procedures, including living donors, are developed and maintained by the Cigna Healthcare® Clinical Review Unit (medical management unit) under the direction of Cigna LifeSOURCE medical directors.

When appropriate, the following guidelines are used for prior authorization, concurrent and retrospective review of coverage for transplant-related services, nontransplant services and procedures, inpatient admissions, and home care services:

- Milliman Care Guidelines for elective and emergent, inpatient, outpatient, and home care services.
- Optimal treatment guidelines (OTG) for appropriateness of surgical procedures and alternative diagnostic and treatment approaches.
- Tools to administer benefits (TABS) and administrative policies and procedures (APP).

Cigna LifeSOURCE recognizes that transplant procedures are varied and change as medicine advances. For up-to-date Cigna LifeSOURCE coverage criteria, log in to the Cigna for Health Care Professionals website (**CignaforHCP.com**) and go to Resources > Coverage Policies > Medical and Administrative Policy Categories: View Documents > Transplants. From there, you can click on the procedure to find the transplant criteria.

Patient handbook

Your patients with Cigna Healthcare® coverage who are identified as potential transplant patients will receive a handbook, "By Your Side," which includes extensive information on how they can best use their benefits.

Patients can also request a handbook from their transplant case manager.

Referrals and appeals

Clinical coverage decisions and appeals

Prior authorization

Prior authorization is ***required*** for each zone and all zone movement. It is required:

- For consultations for transplants (even if not asking for evaluation approval).
- To facilitate agreement to zone dates.
- To validate eligibility and coverage.
- For all intravenous immunoglobulin (IVIg), cardiac assist devices, clinical trials, and donor searches (related and unrelated).
- For additional surgical procedures performed on the same day as the transplant procedure or in the same admission as the transplant.

Prior authorization process

To request prior authorization, call **800.668.9682** and follow the prompts to reach a transplant referral analyst or send a fax to **877.598.2824**.

Upon receipt of a request, an analyst will assign the case to a transplant case manager and benefit specialist. The transplant case manager will then contact you to inform you of the patient's basic transplant coverage.

If transplant is recommended following evaluation, you should contact the transplant case manager with evaluation testing results and a letter recommending transplant event approval.

Coverage determinations

Only a Cigna Healthcare® medical director can deny authorization for clinically based services. A patient, their authorized representative, or a provider has the right to appeal a denial.

Appeals of coverage determinations

This process generally includes provisions for expedited appeals (where appropriate), at least one level of internal appeal and, in many instances, an external review conducted by an independent review organization. The appeals process may be adjusted to comply with state and federal guidelines.

Clinical trial determinations

Participation in a clinical trial depends on the patient's specific benefit plan language and on legislative mandates. Please discuss a patient's candidacy for a clinical trial with the transplant case manager prior to signing them up.

Transplant case management referral process

You must contact and obtain authorization from a transplant case manager before providing any services. To do so, use one of the following options:

- Download and complete the **Cigna LifeSOURCE Transplant Network® Referral Form** and fax it to **877.598.2484**.
- Call the Transplant Case Management Unit at **800.668.9682** and provide the following information:
  - Patient's first and last name, with spelling.
  - Patient's Cigna Healthcare® ID number.
  - Your name and return telephone number.
  - Transplant type requested and date of planned evaluation or procedure (if known).

Your case will be assigned to a transplant case manager who will verify the patient's eligibility, review coverage information, and contact the provider, facility, and patient.

Medical documentation checklists

Case managers in the Transplant Case Management Unit use specific checklists for transplants and Advanced Cellular Therapy (ACT) to ensure all needed tests have been completed and submitted. To perform the most complete review possible, transplant case managers will typically request the information in the checklists on pages 20–25. Please use these checklists to assist us with managing your patient's coverage. If a box has an X, we ask that you provide the information for the corresponding transplant treatment.

Please include all documents that contain or refer to the information the provider or hospital reviewed or relied upon in reaching the decision to perform a transplant procedure. Note that a coverage decision will **not** be made until these records are received and reviewed.

Medical documentation is necessary for referrals for evaluation and should be obtained from the primary care provider (PCP) or specialty care provider (SCP).

A letter of medical necessity describing the transplant procedure or clinical data to support the request should also be requested for all patients.

Medical documentation needed for each zone

- **Zone 1:** Letter of medical necessity, medical history and physical examination, and pertinent lab work.
- **Zone 2:** Specific to age/gender and organ type (testing listed below).
- **Zone 3:** Notification of outpatient or inpatient stay for the transplant (or chimeric antigen receptor [CAR] T-cell therapy) for the initial authorization. (We will work with the inpatient team to obtain clinical information for continued stay reviews/discharge planning.)
- **Zone 4:** Initial notification of discharge. (We will outreach the facility for clinical updates.)

Note: Notification of any inpatient admission is required during any of the zone time frames.

Medical documentation checklist for adult transplants

		Allogenic stem cell/bone marrow	Autologous stem cell/bone marrow	Advanced Cellular Therapy (including chimeric antigen receptor [CAR] T-cell and T-cell receptor [TCR] therapy)	Heart or heart/lung	Kidney	Liver, intestine, or multivisceral	Lung	Pancreas or kidney/pancreas	Tumor-infiltrating lymphocyte (TIL)
Cardiopulmonary										
	Chest X-ray or computed tomography (CT)	X	X	X	X	X	X	X	X	X
	Magnetic resonance imaging (MRI) or CT of thorax							X		
	Electrocardiogram (EKG)	X	X	X	X	X	X	X	X	X
	Echocardiography or cardiac catheterization				X			X		
	Echocardiography or other cardiac functional test (multigated acquisition	X	X	X						X

		Allogenic stem cell/bone marrow	Autologous stem cell/bone marrow	Advanced Cellular Therapy (including chimeric antigen receptor [CAR] T-cell and T-cell receptor [TCR] therapy)	Heart or heart/lung	Kidney	Liver, intestine, or multivisceral	Lung	Pancreas or kidney/pancreas	Tumor-infiltrating lymphocyte (TIL)
	[MUGA]/cardiac catheterization [CATH]) that evaluates ejection fraction (EF) and valvular status									
	Cardiac clearance (if abnormal from physical exam or history of heart failure or heart disease)					X	X		X	
	Pulmonary function testing (spirometry and volumes)	X			X			X		
	Pulmonary ventilation/perfusion (VQ) scan or CT angiogram (for heart/lung transplants if history of deep vein thrombosis (DVT) or pulmonary embolism or evidence of pulmonary hypertension on echocardiography or cardiac catheterization)				X			X		
Labs										
	Complete blood count (CBC), chemistry panel, liver profile, and renal profile	X	X	X	X	X	X	X	X	X
	Estimated glomerular filtration rate (GFR) or creatinine clearance if not on dialysis					X				
	Estimated GFR or creatinine clearance if level is greater than 2.0						X	X	X	
	Hemoglobin (Hgb) A1c								X	
	ABO blood type	X			X	X	X	X	X	
	Human Leukocyte Antigen (HLA) Typing	X								

		Allogenic stem cell/bone marrow	Autologous stem cell/bone marrow	Advanced Cellular Therapy (including chimeric antigen receptor [CAR] T-cell and T-cell receptor [TCR] therapy)	Heart or heart/lung	Kidney	Liver, intestine, or multivisceral	Lung	Pancreas or kidney/pancreas	Tumor-infiltrating lymphocyte (TIL)
	Human immunodeficiency virus (HIV) status	X	X	X	X	X	X	X	X	X
	Hepatitis serologies	X	X	X	X	X	X	X	X	X
	C-peptide level								X	
	Abdominal CT, MRI, or ultrasound						X			
Cancer surveillance										
	Age 45 to 75 – age- and condition- appropriate colon cancer screening (can include colonoscopy or sigmoidoscopy or fecal occult blood test X3, positron emission tomography [PET] scan, computed tomographic [CTC]/virtual colonoscopy, stool-based deoxyribonucleic acid [DNA; e.g., Cologuard®])	X	X	X	X	X	X	X	X	X
	Females (age 21 and older) – gynecological exam with Pap smear within the past three years unless absolute neutrophil count (ANC) less than 1,000 (or recent ultrasound, CT, MRI, or PET scan of the pelvis, unless history of total hysterectomy and oophorectomy)	X	X	X	X	X	X	X	X	X
	Females (age 50 to 75) – mammography within the past three years or recent ultrasound, MRI, or PET scan	X	X	X	X	X	X	X	X	X
Other requirements										
	Recent history and complete physical examination (including rectal/pelvic, breast, and oral/dental, unless	X	X	X	X	X	X	X	X	X

		Allogenic stem cell/bone marrow	Autologous stem cell/bone marrow	Advanced Cellular Therapy (including chimeric antigen receptor [CAR] T-cell and T-cell receptor [TCR] therapy)	Heart or heart/lung	Kidney	Liver, intestine, or multivisceral	Lung	Pancreas or kidney/pancreas	Tumor-infiltrating lymphocyte (TIL)
	contraindicated) within one year of referral									
	Psychosocial evaluation performed at the transplant center	X	X	X	X	X	X	X	X	X
	Documentation of candidacy approval by facility selection committee				X	X	X	X	X	
	Model for end-stage liver disease (MELD) score						X			
	Dental clearance, if abnormal physical exam	X	X	X	X	X	X	X	X	X
	Purified protein derivative (PPD) testing for tuberculosis with history of exposure, past history, or family history of tuberculosis or abnormal chest X-ray	X	X	X	X	X	X	X	X	X
	Protocol or written transplant treatment plan	X	X	X						
	Additional testing or clearance required by the transplant team to address any comorbidities not included above	X	X	X	X	X	X	X	X	

Medical documentation checklist for pediatric transplants

		Allogenic stem cell/bone marrow	Autologous stem cell/bone marrow	Advanced Cellular Therapy (including chimeric antigen receptor [CAR] T-cell and T-cell receptor [TCR] therapy)	Heart or heart/lung	Kidney	Liver, intestine, or multivisceral	Lung	Pancreas or kidney/pancreas
Cardiopulmonary									
	Chest X-ray or computed tomography (CT)	X	X	X	X	X	X	X	X
	Electrocardiogram (EKG)	X	X	X	X	X	X	X	X
	Echocardiography or cardiac catheterization				X			X	
	Echocardiography or other cardiac functional test (multigated acquisition [MUGA]/cardiac catheterization [CATH]) that evaluates ejection fraction (EF) and valvular status	X	X	X					
Labs									
	Complete blood count (CBC), chemistry panel, liver profile, and renal profile	X	X	X	X	X	X	X	X
	Hemoglobin (Hgb) A1c								X
	Estimated glomerular filtration rate (GFR) or creatinine clearance if not on dialysis					X			
	Estimated GFR or creatinine clearance if level is greater than 2.0						X		X
	ABO blood type	X	X	X	X	X	X	X	X
	Human Leukocyte Antigen (HLA) Typing	X							
	Human immunodeficiency virus (HIV) status	X	X	X	X	X	X	X	X
	Hepatitis serologies	X	X	X	X	X	X	X	X
Other requirements									
	Recent history and complete physical examination (including oral/dental component and breast/rectal/pelvis examination as age and condition appropriate)	X	X	X	X	X	X	X	X

		Allogenic stem cell/bone marrow	Autologous stem cell/bone marrow	Advanced Cellular Therapy (including chimeric antigen receptor [CAR] T-cell and T-cell receptor [TCR] therapy)	Heart or heart/lung	Kidney	Liver, intestine, or multivisceral	Lung	Pancreas or kidney/pancreas
	Abdominal CT, magnetic resonance imaging (MRI), or ultrasound						X		
	Psychosocial evaluation of caregivers performed at the transplant center	X	X	X	X	X	X	X	X
	Documentation of candidacy approval by facility selection committee				X	X	X	X	X
	Pediatric end-stage liver disease (PELD) score						X		
	Protocol or written transplant treatment plan	X	X	X					
	Purified protein derivative (PPD) testing for tuberculosis with history of exposure, past history, or family history of tuberculosis or abnormal chest X-ray	X	X	X	X	X	X	X	X
	Dental clearance, if abnormal physical exam	X	X	X	X	X	X	X	X
	Additional testing or clearance required by the transplant team to address any comorbidities not included above	X	X	X	X	X	X	X	X
	New York Heart Association Functional Classification				X			X	

Note: If a living donor is being considered for a patient, there is additional information required for review per United Network for Organ Sharing and Organ Procurement and Transplantation Network (OPTN) policies. This includes verbal or written confirmation of psychosocial evaluation, completion of independent living donor advocate (ILDA), donor medical evaluation (physical evaluation and lab work), and donor informed consent.

These checklists are a guide and are not absolute. Please contact your patient's transplant case manager if you have questions or concerns. A printer-friendly version of these **medical documentation checklists** is available.

Medicare eligibility

For your patients with end-stage renal disease and kidney transplants, answer these questions to determine Medicare eligibility:

- Does the patient have end-stage renal disease and are they on dialysis?
- Will the patient be receiving a kidney transplant without having started dialysis prior to the transplant?

If you answered yes to either of the above questions, the patient may be eligible for Medicare Parts A and B, regardless of age. You should follow up with the transplant case manager to review the patient's benefit plan for coverage limitations that may apply when they are eligible for Medicare. The benefit plan may assume enrollment in both Medicare Parts A and B and pay as secondary even if the patient is not enrolled in Medicare.

Strategic Alliances, Shared Administration Repricing, and Payer Solutions

Payer Solutions

We contract with third-party administrators (TPAs), selected insurers, and claim administrators (referred to collectively as "payers") to share the administration of self-funded and insured plans. For these relationships, we provide access to our preferred provider organization, Open Access Plus, and LocalPlus® networks; may perform medical management; and price claims according to our negotiated rates. For some employer groups, we also provide stop loss insurance, chronic condition management, pharmacy benefits, and other products. Our contracted payers maintain eligibility, administer benefits, and process claims for these accounts on their own systems.

Shared Administration Repricing

We contract with Taft-Hartley trusts and Federal Employee Health Benefits plans to share the administration of self-funded administrative services only (ASO) plans. For these relationships, we provide access to our preferred provider organization, Open Access Plus, and LocalPlus® networks; perform inpatient medical management (and sometimes outpatient, depending on the employer group); and reprice claims according to negotiated rates. For some employer groups, we may also provide stop loss insurance, chronic condition management, and pharmacy benefits. Third-party administrators (TPAs) or employer groups are involved in the administration of these plans with respect to eligibility and claim payment on their own systems.

Strategic Alliances

Some of your patients may have a plan offered through a Cigna Healthcare® Strategic Alliance. This means Cigna Healthcare and another health plan jointly market benefit plans or share in the administration of the plan (e.g., we may perform claim repricing and other services). Individuals with these plans can access in-network care through the alliance plan's network of providers in the alliance plan's select geographic area. In other locations, individuals access care through the Cigna Healthcare network.

We have Strategic Alliances with Priority Health, HealthPartners, and MVP Health Care.

Claims and compensation

Timely and accurate reimbursement is important to you and us. We have several customer service and claim centers throughout the country responsible for processing claims. For some patients with Cigna Healthcare® coverage, a third party, in accordance with our standards, may provide claims processing.

Claims submissions

To ensure accurate and timely claims processing and repricing, please submit claims to the correct address noted in the table below. Do not submit claims to the address on the patient's ID card. In addition, claims cannot be submitted via electronic data interchange (EDI) unless you are eligible and participate in the EDI program.

Plans	Contact information
Cigna Healthcare®, Cigna Global Health Benefits®, and Shared Administration Repricing (Taft-Hartley)	**U.S. mail** Cigna LifeSOURCE Transplant Claims PO Box 182203 Chattanooga, TN 37422 **FedEx, UPS, and certified mail** Cigna LifeSOURCE Transplant Claims 5810 Brainerd Road Chattanooga, TN 37411 **Email** **LifeSOURCETransplantClaims@CignaHealthcare.com**
SAMBA	**U.S. mail** Cigna LifeSOURCE SAMBA PO Box 188007 Chattanooga, TN 37422 **Email** **LifeSOURCETransplantClaims@CignaHealthcare.com**
Network Access Client (NAC; including Payer Solutions)	**U.S. mail** Cigna LifeSOURCE NAC Transplant Claims PO Box 7297 Philadelphia, PA 19101-7297 **FedEx, UPS, and certified mail** Cigna LifeSOURCE NAC Transplant Claims Attn: Cigna Mailroom 1601 Chestnut St Philadelphia, PA 19192 **Email** **NACClaims@Evernorth.com**

Email submissions

All LifeSOURCE claims can be sent via secure email through your Cigna Healthcare established–Transport Layer Security (TLS) connection to **LifeSOURCETransplantClaims@CignaHealthcare.com**. If you do not have a TLS connection established, you can request one via the same email address.

You should only send one email per patient. A **coversheet** is required for every email submitted with claims or with an itemized bill submission. The email should contain two or three separate attachments/files:

- **Claims:** Start the file name with the prefix "cl_" (you can attach more than one claim per file but there must be at least one attached).

- **Required coversheet:** Start the file name with the prefix "cs_" (please make sure all the required information marked with an asterisk is filled out).
- **Itemization:** Start the file name with the prefix "it_" (itemizations are required for zone 3).

EDI submissions

If you are enrolled in EDI, you can submit claims to us as outlined below. If you are not enrolled but would like to be, please email **Jennifer Zawierucha**. **Note:** Claims for NACs cannot be submitted via EDI.

- For zones 1, 2, and 4, please submit claims through payer ID 62308.
- For zone 3, please follow the agreed-upon EDI process.

Bundled billing for paper submissions

If the hospital and providers are reimbursed under a single zone 3 case rate, the hospital must bill all hospital and provider claims for services rendered during the transplant admission, or transplant period, as one packet with a **coversheet**.

Interim bills for zone 3 will be accepted as long as a coversheet is included with each submission. The zone 3 case rate payment will be made on the first packet submission. Contract terms and provisions will continue to apply to the processing of any subsequent zone 3 claims. For bone marrow transplants/stem cell transplants (BMTs/SCTs), a global packet after each cell infusion may be submitted but the packet must include all applicable claims for that transplant period.

If the hospital and provider group have separate zone 3 case rates, they must bundle bill their respective claims as outlined above.

Note: Shared Administration Repricing and NACs will not process a global case rate zone payment unless all hospital and provider claims are included in the packet, even if there are no inlier or outlier provisions that would apply.

Definition of a "Complete Claim"

We define a "Complete Claim" as including the following information at a minimum:

- Patient's name and address.
- Location of service.
- Patient's date of birth and gender.
- Patient's relationship to subscriber.
- Subscriber's name and address.
- Subscriber's ID number and date of birth.
- Subscriber's group number.
- Patient's/subscriber's authorized signature.
- Other insurance information.
- Name of referring provider.
- Transplant case management prior authorization number.
- Admit/discharge date and time.
- Admitting/attending provider.
- Other or secondary insurance information.
- Diagnosis codes (International Classification of Diseases, diagnosis related group).
- Date of current illness.
- First date of same or similar illness.
- Date of service.
- Provider's name, address, and telephone number.
- Taxpayer Identification Number (TIN) and National Provider Identifier (NPI).
- Description of procedure(s).
- Billed charge or amount for each procedure.
- Cigna Healthcare® provider ID number (all digits and suffix).
- Standard code sets (Current Procedural Terminology-4, Healthcare Common Procedure Coding System [HCPCS], valid National Drug Code [NDC], NDC units, HCPCS units, or revenue code to HCPCS combinations as required by Centers for Medicare & Medicaid Services [CMS]/National Uniform Billing Committee/Cigna Healthcare reimbursement policy).

Note: Any state law, Health Insurance Portability and Accountability Act of 1996 (HIPAA) transaction, and code set requirements or plan-specific language inconsistent with the Administrative Guidelines and Program Requirements will supersede these guidelines in the event of a conflict.

Required claim documentation

The following requirements apply to all submissions.

- **Zone authorizations (prior authorizations)** for each zone must be included on Form UB-04 (box 63) or Form CMS-1500 (box 23) and submitted on separate claim forms for each zone.
- **Multiple zones** should not be billed on the same UB-04 claim form, unless specifically identified otherwise in your Agreement. Typically, the charges for each zone should be on a separate UB-04 claim form.
- **Non-transplant-related care** charges should be submitted on a separate UB-04 claim form from the transplant-related care charges.
- **Split years** claims must either be submitted with separate UB-04 claim forms for each year or with an itemization that includes revenue codes and dates of service for each charge.
- **Itemized bills** are required to process your claim and must always include the revenue code and date of service for each charge.
- **Donor claims** should be billed under the transplant recipient's name and Cigna Healthcare® ID number and clearly marked as a donor claim. The donor's name can be included as a remark and the donor's authorization number should be included on the claim.

Once a patient enters transplant case management, all claims, including those for non-transplant-related services, are handled by our dedicated transplant claims teams. This dedicated service continues for one year after the transplant procedure to ensure that all related claims are reimbursed accurately.

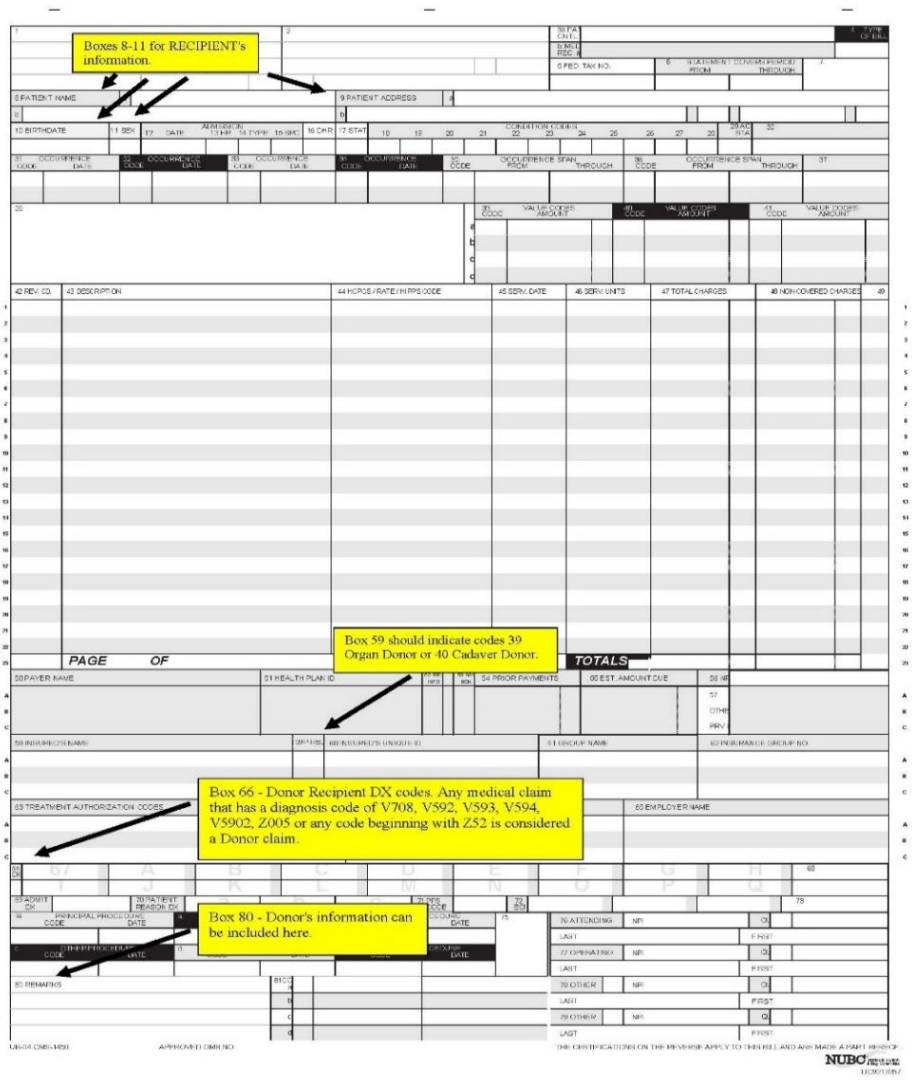
Donor claim submissions

The transplant recipient's insurance plan is responsible for paying the donor claim. For donor claims, please bill with the recipient's patient and billing information as detailed below.

CMS-1450 (UB-04)

- Box 8b – Recipient's name.
- Box 10 – Recipient's birthdate.
- Box 11 – Recipient's sex.
- Box 42 – Donor International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes and revenue codes.
- Box 58 – Subscriber's name.
- Box 59 – Relationship code (39 or 40).
- Box 60 – Subscriber's ID number.
- Box 66 – Donor diagnosis codes.
- Box 80 – Note indicating this is a donor claim submission with donor's name.

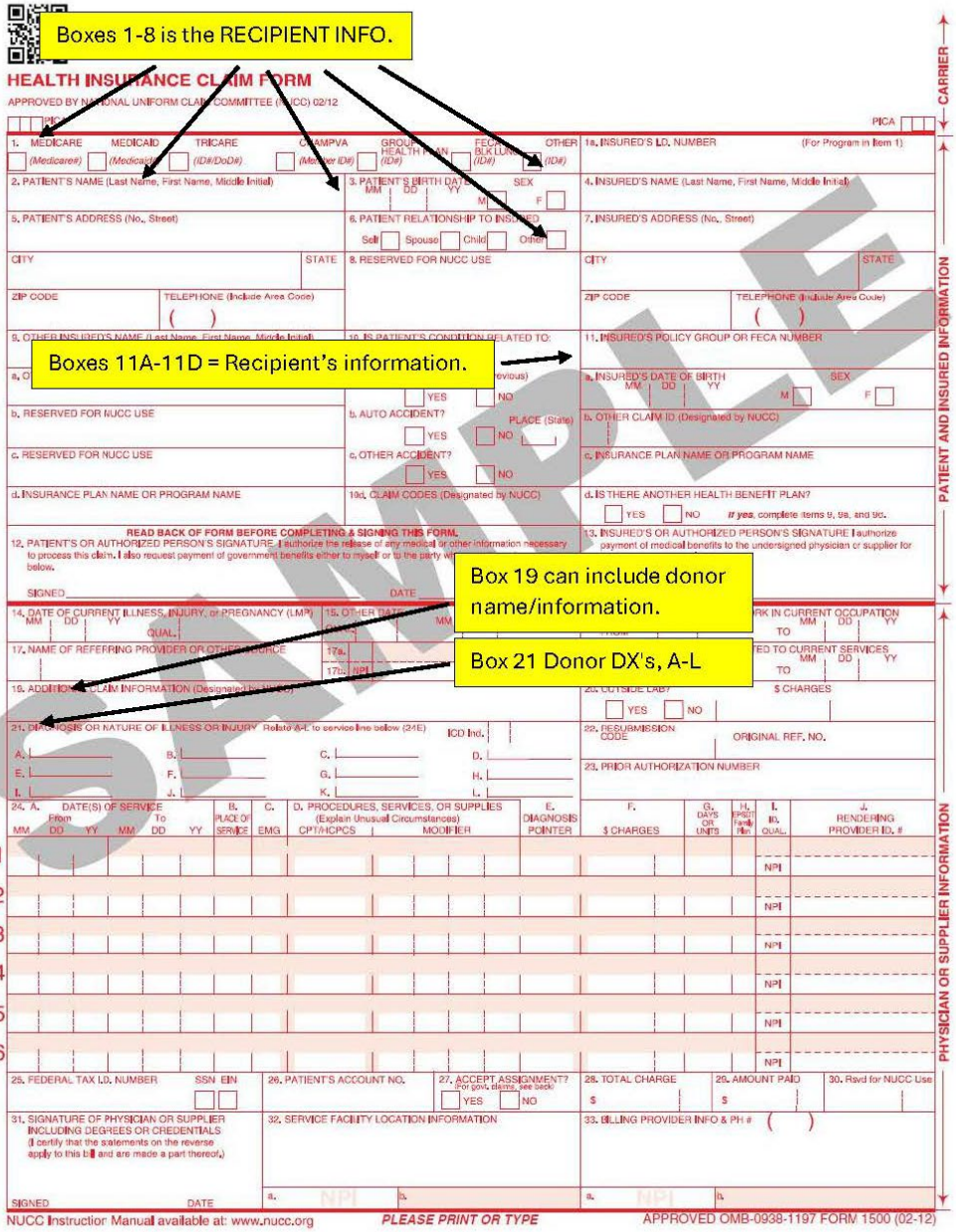
An example of this form is on the next page.



CMS-1500 (Health Insurance Claim Form)

- Box 1a – Subscriber's ID number.
- Box 2 – Recipient's name.
- Box 3 – Recipient's date of birth and gender.
- Box 4 – Subscriber's name.
- Box 6 – Relationship to subscriber (other; box should indicate code 39 [organ donor] or 40 [cadaver donor]).
- Box 19 – Note indicating this is a donor claim submission with donor's name.
- Box 21 – Donor diagnosis codes.
- Box 53 (electronic claim) – Donor's name.

An example of this form is on the next page.


Boxes 1-8 is the RECIPIENT INFO.
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12
CARRIER
PICA
PATIENT AND INSURED INFORMATION
Boxes 11A-11D = Recipient's information.
Box 19 can include donor name/information.
Box 21 Donor DX's, A-L
PHYSICIAN OR SUPPLIER INFORMATION
SAMPLE
NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)

Claims filing deadline

Claims should be filed as soon as possible to promote prompt payment. We will only consider claims submitted within 90 days of the date of service or as otherwise defined in your Agreement and the exceptions noted below.

For services rendered on consecutive days, such as for a hospital confinement, the filing limit will be counted from the last date of service.

Hospitals can submit interim bills for long hospital confinement within any transplant zone. When submitting interim billing, hospitals should ensure the coding reflected in the claim is for an interim status bill and the correct bill type is being used. We recommend interim billings be submitted for a minimum of 30 days of service. Interim bills for zone 3 require a **coversheet** with each submission.

The following are current exceptions to the 90-day time limit:

- Applicable state law provides for a longer timely filing limit in which case that time limit will apply.
- Coordination of benefits (COB; 90-day filing limit is applied based on the primary carrier's processing date as stated on an explanation of benefits [EOB] or explanation of payment [EOP]).
- Resubmission of a claim originally filed in a timely manner, returned with new or additional information as requested by us (90-day filing limit is reset to the date of the request for more information).
- Services provided to patients through arrangements with third-party vendors (filing limit is applied based on third-party requirements, which may be more or less than 90 days).
- Extenuating circumstances (e.g., catastrophic events).

Claims inquiry

For Cigna Healthcare®, Cigna Global Health Benefits®, Shared Administration Repricing (Taft-Hartley), and SAMBA, please call **800.287.0539** to check on the status of transplant claims. For Network Access Clients (NACs; including Payer Solutions), please send an email to **LifeSOURCENACInquiries@Evernorth.com** with the patient's name, date of birth, and ID number, dates of service, and billed charges amount.

Claims payment policies and procedures

Claims from in-network providers are subject to our claims payment policies and procedures. These policies are the guidelines we adopted for calculating payment of claims and include our standard claim code auditing methodology, review of charges compared to services provided, and procedures for claims adjudication.

The **Omnibus Reimbursement Policy – (R24)** includes the following reimbursement information.

Policy name	Policy detail	Claim form
Organ Transplant	Organ transport and procurement are considered integral to the primary transplant procedure and will not be separately reimbursed.	CMS-1500 and UB-04

Denied payment and patient nonliability

You cannot bill your patients with Cigna Healthcare® coverage for covered services or for services for which payment was denied due to your failure to comply with your Agreement or Administrative Guidelines and Program Requirements, including Cigna LifeSOURCE case management requirements and timely filing requirements.

Coordination of benefits

Your patients may be covered by more than one health benefit plan. In some cases, payment may be the primary responsibility of another payer. Billing multiple health benefit plans to obtain payment is called

coordination of benefits (COB). You should assist us to maximize recoveries under COB and bill services to the primary payer. After receiving a payment or denial notice from the primary payer, you should submit the COB claim electronically to Cigna Healthcare®. However, if you submit COB claims on paper, then a copy of the primary payer's explanation of payment (EOP) is required.

Cigna Healthcare payer ID 62308 can receive COB claims electronically; please contact your vendor for information on how to submit these claims. For more information about electronic claims, go to the **claims submission section**.

Cigna Healthcare as primary payer

When the Cigna Healthcare plan is the primary payer, payment is made in accordance with your Agreement with Cigna Healthcare without regard to the secondary payer. After receiving payment from Cigna Healthcare, you should submit the COB claim to the secondary payer.

Cigna Healthcare as secondary payer

When the Cigna Healthcare plan is the secondary payer, you should first submit the claim to the primary payer. After receiving a payment or denial notice from the primary payer, you should submit the claim to Cigna Healthcare, along with a copy of the primary payer's EOP. Paper copies are not required if you submit Health Insurance Portability and Accountability Act of 1996–compliant (HIPAA-compliant) COB content electronically through an electronic data interchange (EDI) claims submission.

We participate in the Medicare Coordination of Benefits Agreement, also known as Medicare Crossover, for individuals whose coverage is made available through Medicare Parts A and B. This eliminates the need for you to submit Medicare COB claims to Cigna Healthcare. The Medicare explanation of benefits (EOB) or electronic remittance advice (ERA) will show that those claims were forwarded to Cigna Healthcare as the secondary payer.

Our payment as a secondary payer, when added to the amount payable from other sources under the applicable COB rules, will be no greater than the payment for covered services under your Cigna Healthcare Agreement and is subject to the terms and conditions of the patient's health benefit plan and applicable state and federal law. Use of applicable COB provisions may result in a payment from Cigna Healthcare, when added to the amount payable from other sources, which is less than 100 percent of your payment for covered services under your Cigna Healthcare Agreement.

When Medicare is the primary payer and the Cigna Healthcare plan is the secondary payer, applicable Medicare billing rules (including Medicare COB rules) will apply to your reimbursement. The financial responsibility of the Cigna Healthcare plan as a secondary payer under Medicare COB rules is limited to the patient's financial liability (i.e., the applicable Medicare Copay, Coinsurance, and/or Deductible) after application of the Medicare-approved amount. The Medicare payment plus the patient liability amounts constitutes payment in full, and you are prohibited from collecting any monies in excess of this amount.

Payment integrity: claim quality and accuracy

We manage claims and perform reviews through various quality and cost-focused programs. These programs continue to provide quality results that can help improve both cost-effectiveness and our customers' experience.

Complex clinical claim review

The complex clinical claim review program evaluates claims for accuracy and appropriateness before a benefit payment determination is made. As part of this program, an experienced team of professionals — including nurses, certified coders, and physicians — reviews billing and coding to confirm accurate reporting; examines submitted documentation; reviews submitted claims against applicable coverage, payment, and reimbursement policies; and verifies coverage for services under the terms of the patient's benefit plan.

Prepayment review

The prepayment review program works in harmony with other programs to enhance claims processing accuracy. The program's goal is to better manage and finalize claims on a prepayment basis, which is accomplished by identifying claims that require additional review beyond standard or automatic processing in the claims systems. This nonstandard handling permits the team to work claims individually and help ensure correct payment.

Post-payment review

The post-payment review program is responsible for analyzing claims after they have been paid. Nurse and physician reviewers compare a facility's itemized bill and invoices to the events, services, and supplies reported in the patient's medical record. This team also verifies the codes submitted on the claim meet our reimbursement policies and accurately represent documented services.

Dispute resolution

Payment appeals

Payment disputes should be submitted to the Cigna Healthcare® National Appeals Organization.

All appeals must be initiated in writing within 180 calendar days of the date of the initial payment or denial decision. If the appeal relates to a payment that we adjusted, the appeal must be initiated within 180 calendar days from the date of the last payment adjustment.

The appeal process aims to resolve contractual disputes about post-service payment denials (or partial denials) and other payment disputes. If the issue is not resolved to your satisfaction, you may request a dispute resolution, including arbitration, as the final resolution step.

For additional information on how to submit an appeal, review and follow the **Appeal Policy and Procedures for Health Care Professionals guidelines** on the Cigna for Health Care Professionals website (**CignaforHCP.com**).

For questions or more information, please contact the patient's transplant case manager or the customer service number on the back of the patient's ID card.

Arbitration

If you are still not satisfied after completing the internal appeal process, you may request dispute resolution including arbitration. This is a binding, final resolution for the regarding claim.

The process for arbitration may be specified in your Agreement. If it is not specified in your Agreement and is not prohibited by state law, the following process will apply.

If the dispute is not resolved through the appeal processes described above, either party can initiate arbitration by providing written notice to the other. The appeal processes must be followed in their entirety before initiating arbitration. If one of the parties initiates arbitration, the proceeding will be held in the jurisdiction of the provider's domicile. The parties will jointly appoint a mutually acceptable arbitrator. If the parties are unable to agree upon such an arbitrator within 30 days after one of the parties has notified the other of the desire to submit a dispute for arbitration, then the parties will prepare a Request for a Dispute Resolution List and submit it to the American Health Lawyers Association Alternative Dispute Resolution Service (AHLA ADR Service), along with the appropriate administration fee. Under the Code of Ethics and Rules of Procedure developed by the AHLA ADR Service, the parties will be sent a list of 10 arbitrators along with a background and experience description, references, and fee schedule for each. The 10 arbitrators will be chosen by the AHLA ADR Service based on their experience in the area of the dispute, geographic location, and other criteria as indicated on the request form. The parties will review the qualifications of the 10 suggested arbitrators and rank them in order of preference from one to nine. Each party has the right to strike one of the names from the list. The person with the lowest total will be appointed to resolve the case.

Each party will assume its own attorney's fees and all of its costs of arbitration; however, the compensation and expenses of the arbitrator along with any administrative fees or costs will be borne equally by the parties. Arbitration is the exclusive remedy for the resolution of disputes under the parties' agreement. The decisions of the arbitrator will be final, conclusive, and binding, and no action at law or in equity may be instituted by the parties other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision will not be consolidated with an arbitration involving other physicians or third parties, and that the arbitrator will be without power to conduct an arbitration on a class basis. Judgment upon the award rendered by the arbitrator may be entered in any court of competent jurisdiction.

Travel benefit

We offer a travel and lodging benefit up to $10,000 to eligible transplant recipients when they choose a Cigna LifeSOURCE designated program.

The benefit covers eligible transportation and lodging for the transplant recipient and one caregiver (up to two caregivers for a dependent minor) when we have authorized coverage for a transplant at a Cigna LifeSOURCE Network facility that is designated for the specific transplant being requested and when the facility is located more than 60 miles (one way) from the recipient's home.

This benefit may not be the same for all recipients.

Recipients may be eligible for a travel card to assist with costs. The case manager will be able to assess for and educate on this benefit.

Air ambulance transport

Air ambulance transport is covered when medically necessary only if the individual's medical condition is such that transportation by basic or advanced life support is required and ground ambulance is not clinically appropriate, available, or feasible.

Important points to note:

- Coverage for air ambulance transport is limited to the closest appropriate Cigna LifeSOURCE Network center.
- All air ambulance transport, if covered, for a transplant event or related service is a core medical benefit and is not eligible for reimbursement under the transplant travel benefit. The standard air ambulance benefit applies.
- Air ambulance transport provided solely for the convenience of the individual is not a covered benefit. Air ambulance is considered a convenience for an individual who chooses to remain outside a reasonable driving distance from the transplant facility while on the waiting list. An individual is expected to remain within a reasonable driving distance from the transplant facility to allow safe transport to the transplant facility within the time frame specified by the facility when an organ becomes available for transplant.

We are contracted with several air ambulance companies. Please work with the Cigna LifeSOURCE case manager to contact a contracted air ambulance provider when appropriate and medically necessary. If an urgent situation arises after business hours, please contact the Cigna Healthcare® 24-Hour Health Information Line at **800.856.9286** to arrange for these services.

Network Access Clients

Network Access Clients (NACs) contract with us specifically to access the Cigna LifeSOURCE Network for their payers needing transplant benefit management and support. These clients do not have benefit plans for which Cigna Healthcare® is the claims administrator, including Cigna Payer Solutions. Cigna Healthcare currently has this arrangement with approximately 400 different payers.

Referral process

Payers can initiate the referral process by filling out a referral form and sending it to Cigna LifeSOURCE. Upon receipt of the form, one of our transplant care coordinators (TCC) will review it to ensure it is complete and that the benefits are adequate. They will then forward a referral letter (sample below) via fax, unless an email is requested, to the appropriate contacts at your organization, typically the financial coordinator at the transplant program and managed care office.

Sample Referral Notification.pdf

The TCC follows up on a regular basis with the transplant program and the payer's case manager. They do this to check on the status of a case, including whether the patient remains a candidate for transplant, and to confirm zone dates as well as the date the case is closed. This helps to keep all parties informed and ensures that everyone agrees on the patient's status, whether pre-transplant admissions are transplant related or not, and to ensure accuracy in repricing of claims.

For questions about referrals, please contact Sarah Shafer at **860.902.9604** or **Sarah.Shafer@Evernorth.com**.

Claims process

Claims should be submitted using one of the following options:

- **U.S. mail:** Cigna LifeSOURCE NAC Transplant Claims, PO Box 7297, Philadelphia, PA 19101-7297.
- **FedEx:** Cigna LifeSOURCE NAC Transplant Claims, Attn: Cigna Mailroom, 1601 Chestnut St, Philadelphia, PA 19192.
- **Email:** **NACClaims@Evernorth.com**.

If you send claims to the Cigna LifeSOURCE address in Chattanooga, they will most likely be denied and returned to your billing department.

A dedicated Cigna LifeSOURCE claims representative reprices claims and the average turnaround time is five business days. The repriced claims are sent to the appropriate payer for processing. If there are any questions or concerns about an amount that the payer has paid on a particular claim (or batch of claims) or if there is nonpayment of a claim, please contact the NAC claims team at **LifeSOURCENACInquiries@Evernorth.com**.

Cigna LifeSOURCE will reprice claims for all four zones. At the time, if we find out that a case is ready to be closed under the terms of our Agreement, we will fax a letter, unless an email is requested, stating that Cigna LifeSOURCE is preparing to close the case, provide the case closure date, and request final submission of claims.

For additional information about claims submissions (e.g., claim requirements), refer to the **claims and compensation section**.

Pharmacy, infusion services, and behavioral health services

Express Scripts Pharmacy

Express Scripts® Pharmacy, our home delivery pharmacy, delivers specialized care that puts patients first and makes prescription medications safer and more affordable.

Our home delivery pharmacy provides the following for initial discharge orders post-transplant:

- Prescription-only medications associated with transplants.
- Some transplant-related over-the-counter (OTC) medications.
- Diabetic supplies, blood pressure medications, and cholesterol medications.
- 90-day supplies.
- Free, overnight shipping directly to the hospital or patient.

Our home delivery pharmacy can bill Cigna Healthcare® directly for the medications and can bill Medicare as either a primary or secondary payer for covered immunosuppressive medications for eligible patients.

You can submit an order by calling **800.211.1456** or sending a fax to **800.351.3616**.

Accredo Specialty Pharmacy

Accredo® Specialty Pharmacy (Accredo) is the national preferred source for specialty medications and is in the pharmacy network for many of your patients with Cigna Healthcare® plans. By using an in-network pharmacy, your patients will be able to take full advantage of their specialty drug coverage options.

Through Accredo, you and your patients have access to a team of pharmacists and nurses with extensive training and experience. You will be able to obtain specialty products, including many limited distribution drugs (LDDs) or those with exclusive distribution, and your eligible patients will be able to obtain financial assistance coordination.

Additional information about Accredo, as well as **referral forms**, are available on **Accredo.com**.

You can contact Accredo for specialty medication prescriptions and renewals at **844.516.3319**.

Behavioral health

For the entire time your patient is in transplant case management through Cigna LifeSOURCE, they must work with their transplant case manager for behavioral health coverage. The case manager will work with Evernorth® Behavioral Health to provide behavioral health benefits to your patients, including crisis counseling by telephone, one-on-one counseling, and inpatient psychiatric counseling.

Your patient's transplant case manager can confirm their behavioral health coverage. For more information about behavioral health benefits and eligibility, please visit **Provider.Evernorth.com** or call the Evernorth Behavioral Health Program at **800.926.2273**.

National ancillaries

Our national ancillary programs directly respond to our customers' and employer groups' requests for access to cost-effective, quality services and more information on health care options.

Program goals

Our goals include the following:

- Expand access to quality providers.
- Increase quality of care and patient safety.
- Educate our customers about their health care options.
- Administer services in accordance with plan benefits and applicable coverage and reimbursement policies.

To achieve these goals, we collaborate with select ancillary providers, like those listed below, to help ensure services are medically necessary and that quality care is received. **Note:** This list is not all-inclusive of every national ancillary provider. Ancillary providers do not manage services in all states and markets.

Service	Provider	Description	Contact information
Acupuncture care	American Specialty Health® (ASH)	ASH provides acupuncture network management, utilization management, and claims management services for Cigna Healthcare® customers in certain markets. ASH performs medical necessity review and provides a network of acupuncturists for Cigna Healthcare customers with Health Maintenance Organization (HMO), Network, Point of Service (POS), Open Access, Open Access Plus (OAP), Preferred Provider Organization (PPO), and LocalPlus® medical benefit plans. ASH also reviews claims from out-of-network acupuncturists for medical necessity. Acupuncturists must be contracted with ASH to provide in-network services to Cigna Healthcare customers in the affected markets.	Telephone: **800.972.4226** Website: **ASHCompanies.com**
Chiropractic care	ASH	ASH provides chiropractic network management, utilization management, and claims management services for Cigna Healthcare customers in certain markets. ASH performs medical necessity review and provides a network of chiropractors for Cigna Healthcare customers with HMO, Network,	Telephone: **800.972.4226** Website: **ASHCompanies.com**

		POS, Open Access, OAP, PPO, and LocalPlus medical benefit plans. ASH also reviews claims from out-of-network chiropractors for medical necessity. Chiropractors must be contracted with ASH to provide in-network services to Cigna Healthcare customers in the affected markets.	
Dialysis	DaVita® Fresenius Medical Care U.S. Renal Care Pure Life Renal	DaVita, Fresenius Medical Care, U.S. Renal Care, and Pure Life Renal provide access to a network of dialysis centers and numerous services, including hemodialysis, peritoneal dialysis, transplant support, nutritional counseling, laboratory testing, and various supplies, for Cigna Healthcare customers. They are recognized nationally as leading providers of dialysis services, providing care for those with chronic kidney failure and end-stage renal disease.	**DaVita** Telephone: **800.244.0680** Website: **DaVita.com** **Fresenius Medical Care** Telephone: **800.662.1237** Website: **FreseniusKidneyCare.com** **U.S. Renal Care** Telephone: **866.671.8772** Website: **USRenalCare.com** **Pure Life Renal** Telephone: **954.962.5733** Website: **PLRenal.com**
Durable medical equipment (DME) and home health care	EviCore by Evernorth® (EviCore)	EviCore manages home health services and DME for Cigna Healthcare customers. EviCore has a national network of providers that providers can access to coordinate care for Cigna Healthcare customers through the **Cigna Healthcare provider directory**. Providers can also contact EviCore to assist with coordination of home care services. This service is available 24 hours a day, seven days a week. EviCore can help arrange the following in-home care and services for Cigna Healthcare customers: • DME (beds, standard wheelchairs, scooters, walkers, etc.). • Breastfeeding equipment and supplies. • Home health care (nursing, therapy services, social work, and home health aides). • Home infusion products. • Insulin pumps and related supplies, wound suction	Telephone: **800.298.4806** Website: **EviCore.com/EP360**

		devices, prothrombin time monitors, and dinamaps. • Respiratory equipment (oxygen, continuous positive airway pressure, and ventilators). • Enteral nutrition (pumps and nutritional support). • Custom-powered wheelchairs and scooters.	
Gastroenterology	EviCore	EviCore administers prior authorization for the following gastroenterology procedures for most Cigna Healthcare commercial customers: • Esophagoscopy/esophagogastroduodenoscopy. • Most capsule endoscopies. Providers must request prior authorization for these services directly from EviCore.	Telephone: **866.668.9250** Website: **EviCore.com/Cigna**
Hearing	Amplifon Hearing Health Care (Amplifon)	Amplifon is our exclusive participating vendor for digital and digitally programmable analog hearing devices and supplies for Cigna Healthcare customers. (This includes Shared Administration Repricing and Payer Solutions customers.) Providers are required to utilize Amplifon to order digital and digitally programmable analog hearing devices and supplies for Cigna Healthcare customers who have hearing aid benefit coverage. There is no cost from the manufacturer to the provider when ordering through Amplifon; therefore, the provider may not bill for hearing aids. Amplifon will pay the manufacturer directly for the hearing aids and will issue a dispensing fee reimbursement to the provider 60 days after the hearing aids have been dispensed provided the customer does not return the hearing aids. All digital and digitally programmable analog hearing devices and supplies that are not ordered through Amplifon for affected customers will be denied, and customers cannot be billed.	Telephone: **855.531.4696** Website: **AmplifonUSA.com/Cigna**

High-tech radiology and diagnostic cardiology	EviCore	EviCore provides high-quality, cost-effective benefit management services to Cigna Healthcare customers in most markets for outpatient, nonemergency, high-tech radiology (e.g., computed tomography [CT] scans, magnetic resonance imaging [MRI], positron emission tomography [PET] scans) and diagnostic cardiology services. Providers must request prior authorization through EviCore for these services for Cigna Healthcare customers. The radiology prior authorization process features improved customer service through the Informed Choice program. EviCore may contact Cigna Healthcare customers to inform them of available in-network radiology service providers. EviCore also provides an in-office credentialing program for low-tech radiology services in the Connecticut, New Jersey, and New York markets.	Telephone: **888.693.3211** Website: **EviCore.com/Cigna**
Infusion therapy services	Accredo® Specialty Pharmacy (Accredo)	Accredo provides home infusion drugs and nursing administration.	Telephone: **844.516.3319** Website: **Accredo.com/Prescribers**
Integrated Oncology Management Program	EviCore	EviCore administers prior authorization for medical oncology medications, including primary chemotherapy and supportive drugs (e.g., medical injectables and infusions) and oral chemotherapy medications, for Cigna Healthcare customers. Providers must request prior authorization for these services directly from EviCore.	Telephone: **866.688.9250** Website: **EviCore.com/Cigna**
Laboratory	Laboratory Corporation of America® (LabCorp®) Quest Diagnostics, Inc. (Quest)	We currently contract with numerous local and national laboratories, including LabCorp and Quest as well as other reference, pathology, genetic, and esoteric laboratories, to provide access to quality services at in-network, cost-effective rates. By referring patients with Cigna Healthcare coverage to a laboratory	**LabCorp** Telephone: **888.LABCORP** Website: **LabCorp.com** **Quest** Telephone: **866.MyQuest** Website: **QuestDiagnostics.com**

		that participates in the Cigna Healthcare network, providers help ensure their patients maximize their benefits while limiting their out-of-pocket expenses. A complete list of in-network laboratories is available in the **Cigna Healthcare provider directory**.	
Lactation counseling	Aeroflow Health Wildflower Health	Aeroflow Health and Wildflower Health, national providers of lactation counseling, support Cigna Healthcare customers who are breastfeeding. Cigna Healthcare customers can access educational resources, ask questions, and seek advice from the comfort of their own home during the third trimester of pregnancy and throughout the postpartum period (including when they return to work). • **Aeroflow Health:** Virtual appointments are available between 10:00 a.m. and 9:30 p.m. ET, with same-day appointments offered depending on availability. A variety of class times are also available seven days a week. • **Wildflower Health:** Virtual appointments are available from 8:00 a.m. to 8:00 p.m. ET, with same-day appointments available. In some markets, face-to-face lactation services are also available. Lactation counseling services from in-network providers are covered at 100 percent and there is no customer cost-share. There is no coverage, or only limited coverage, for lactation counseling services rendered by out-of-network providers, depending on the customer's out-of-network benefit. **Note:** Coordination of benefits will apply if Cigna Healthcare is not the primary payer. A complete list of in-network lactation providers is available in the **Cigna Healthcare provider**	**Aeroflow Health** Telephone: **855.469.0506** Website: **AeroflowBreastPumps.com** **Wildflower Health** Telephone: **855.469.0506** Website: **WildflowerHealth.com/VirtualCare** App: Cigna Healthy Pregnancies® (Virtual appointments can be scheduled via the app.)

		directory. Providers who cannot locate an in-network provider for in-person care should call the number on the back of their patient's ID card.	
Musculoskeletal and pain management services	EviCore	EviCore administers prior authorization for inpatient and outpatient musculoskeletal and pain management services, including major joint surgery services related to the hip, knee, and shoulder and interventional pain management services, for Cigna Healthcare customers in most markets. Providers must request prior authorization for these services directly from EviCore.	Telephone: **888.693.3297** Website: **EviCore.com/Cigna**
Orthotics and prosthetics (O&P)	EviCore	EviCore manages the following O&P services for Cigna Healthcare customers: • O&P devices and supplies. • Postmastectomy supplies. • Wig supplies. • Fabricated splints/braces. • Compression garments. • Off-the-shelf DME products. EviCore is responsible for: • Provider contracting, credentialing, and demographic updates. • Claims processing for Shared Administration Repricing and Payer Solutions customers. • Initial prior authorization requests (forwards requests/information to Cigna Healthcare). • Care coordination efforts. Cigna Healthcare is responsible for: • Claims processing (except for Shared Administration Repricing and Payer Solutions customers). • Customer-based services, including benefits, eligibility, and appeals. • Utilization review and prior authorization. • Provider and customer denial letters for services that are not authorized. EviCore has a national network of providers that providers can access	Telephone: **866.686.4452** Fax: **866.663.7749** Website: **EviCore.com/Cigna**

		to coordinate care for Cigna Healthcare customers through the **Cigna Healthcare provider directory**. Providers can also contact EviCore for assistance with coordination of office- and home-based O&P and off-the-shelf DME products. This service is available 24 hours a day, seven days a week. **Note**: Cigna Healthcare also maintains some relationships with locally contracted O&P providers and several participating national ancillary arrangements with other O&P providers, including DJ Orthopedics, Zimmer Biomet, Nordstrom, and Cranial Technologies.	
Physical therapy (PT) and occupational therapy (OT)	ASH	ASH provides PT/OT network management for individual office locations and virtual care; utilization management; and claims management services for Cigna Healthcare customers in certain markets. ASH manages a medical necessity review program for in-network providers who render PT and OT services in the office for Cigna Healthcare customers with commercial and Individual & Family Plans. Hospitals are excluded from contracting with ASH and the medical necessity review program. ASH also reviews claims from out-of-network PT/OT providers for medical necessity. PT/OT care centers must be contracted with ASH to provide in-network PT/OT services to Cigna Healthcare customers in the affected markets.	Telephone: **800.972.4226** Website: **ASHCompanies.com**
Radiation therapy	eviCore	EviCore administers prior authorization for select radiation therapy services for Cigna Healthcare customers. Providers must request prior authorization for these services directly from EviCore.	Telephone: **866.686.4452** Website: **EviCore.com/Cigna**

Routine vision services	Vision Service Plan (VSP) EyeMed	VSP and EyeMed are our delegated third-party administrator providers of in-network routine eye exams and eyewear services. Providers must contract directly with either VSP or EyeMed to provide in-network services to Cigna Healthcare customers with Vision Preferred Provider Organization (VPPO) coverage. Cigna Healthcare customers will have access to either the EyeMed or VSP network but not both. Cigna Healthcare customers with VPPO coverage may self-refer to an in-network provider for routine vision exams and eyewear as allowed by their plan.	**VSP** Telephone: **800.877.7195** Website: **VSP.com** **EyeMed** Telephone: **888.851.3648** Website: **EyeMedinFocus.com/Join**
Sleep management services	EviCore	EviCore provides a comprehensive sleep management program for Cigna Healthcare customers. As part of this program, EviCore provides Cigna Healthcare customers with access to a robust network of sleep therapy providers, which includes expanded access to sleep testing services in the comfort of the customer's home. Providers must request prior authorization for certain sleep testing services directly from EviCore. During the prior authorization process, EviCore applies medical necessity and place-of-service determinations.	Telephone: **800.298.4806** Website: **EviCore.com/EP360**
Spine surgery, vascular intervention, and molecular laboratory services	EviCore	EviCore administers prior authorization for select spine surgery, vascular intervention, and molecular laboratory services. Providers must request prior authorization for these services directly from EviCore.	Telephone: **866.668.9250** Website: **EviCore.com/Cigna**

Important contact information

Below you will find a list of important contacts. These contacts are available from 8:00 a.m. to 5:00 p.m. Eastern time.

Contact	Position	Telephone	Email
Dr. Isaac Martinez	Senior Medical Director	**480.383.9989**	**Isaac.Martinez@CignaHealthcare.com**
Dr. Aleksandra De Golovine	Medical Director	**713.253.2763**	**Aleksandra.Degolovine@CignaHealthcare.com**
Dr. Maryann Payne	Medical Director	**724.718.5428**	**Maryann.Payne@CignaHealthcare.com**
Dr. Jeff Schriber	Medical Director	**480.244.2142**	**Jeff.Schriber@CignaHealthcare.com**
Adriana Mariani	National Quality Director	**860.902.2973**	**Adriana.Mariani@CignaHealthcare.com**
Arianna Graves	Provider Relations Representative (AZ, CA, CO, IA IL, IN, KS, MI, MN, MO, OH, OR TX, UT, WA, WI; FL [Mayo Clinic])	**404.338.0713**	**Arianna.Graves@CignaHealthcare.com**
Stephanie Hood-Thompson	Provider Relations Representative (AL, AR, CR, DC, DE, FL, GA, KY, LA, MA, MD, ME, NC, NH, NJ, NY, OK, PA, SC, TN, VA, WV)	**615.203.1303**	**Stephanie.Hood-Thompson@CignaHealthcare.com**
Sarah Shafer	Network Access Clients (NACs)	**860.902.9604**	**Sarah.Shafer@Evernorth.com**

Other important contacts:

Contact	Telephone
Cigna LifeSOURCE Transplant Case Management and Referral Line	**800.668.9682**
Cigna LifeSOURCE Customer Service	**800.287.0539**

Legal statement

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc., Express Scripts, Inc., or their affiliates.