PPO Network*

AT A GLANCE

Features. Specifications. Requirements.

This at-a-glance reference tool provides the features, specifications and requirements to deliver Cigna's preferred provider organization (PPO) network product to your clients. This document is intended to provide current product information as of the time it was published. It does not supersede contractual obligations and other detailed plan documents or contracts, including individual contracts with health care professionals.

Product description

Cigna's PPO network*, with national coverage, represents more than 840,000 health care professionals and more than 6,400 facilities, mostly through direct contracts. Additional vendor relationships that are part of Cigna's PPO include:

- Third-party vendor networks (TPVs) in specific ZIP code areas in the following states: Idaho, Illinois, Indiana, Iowa, Hawaii, Kentucky, Michigan, Minnesota, Mississippi, Montana, Nebraska, New York, North Dakota, Oklahoma, Pennsylvania, South Dakota, West Virginia, Wisconsin.
- Ancillary national networks and health care professionals included in Cigna's PPO network:
  - Chiropractic: American Specialty Health, American Therapy Administrators, Columbine Health Plan, Healthways WholeHealth Networks, Preferred Chiropractic Care
  - Dialysis: DaVita, Fresenius
  - Hearing Devices: HearPO
  - Home Health, Home Infusion, DME: CareCentrix®
  - Laboratory: LabCorp, Quest Diagnostics®
  - PT/OT: American Specialty Health, OrthoNet
  - Radiology: MedSolutions

Product snapshot

Minimum group size	Minimum group size is 25 subscribers. Groups with fewer than 25 subscribers may be aggregated by payer to a group greater than or equal to 25. For groups that are Aggregated, subscribers must be reported in aggregate and payment to Cigna must be made in aggregate.
Combined product requirement	Cigna's PPO is packaged with Utilization Management (UM) and the Cigna LifeSOURCE Transplant Network®

Product pricing and sales quotes

Network access fee	Fees are based upon contracted rate agreement.
Underwriting	No underwriting is required for Administrative Services Only (ASO) business
Funding	Payer is responsible for funding.
Three-digit ZIP discount tool	This tool, available to our payers to use as needed, provides average discount information within a three-digit geography. ZIP codes from a census can be used to estimate average discounts at a group level.

*Cigna's PPO network refers to the health care professionals (doctors, hospitals, specialists) contracted as part of the Cigna PPO for Shared Administration.

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Product pricing and sales quotes		
Claim repricing analysis	This report, provided by Cigna and available for groups of 500 or more subscribers, reprices claims against current discounts based on Cigna's repricing methodologies. The following information is required from payer: provider name, Tax Identification Number/National Provider Identifier (TIN/NPI), city, state and ZIP (service address preferred), member ZIP, inpatient/outpatient professional indicator (or place-of-service code), current procedural terminology (CPT) code modifier, service units, submitted charges, non-covered charges and allowable charges. • Estimated turnaround: 11 business days.	
Geo access report	Available to groups with at least 50 subscribers, this report summarizes network access by subscriber ZIP code. • Estimated turnaround: Four business days.	
Disruption reports	Disruption reports provide provider-level detail to compare existing provider utilization to the Cigna network. This report captures provider information at a "point in time," and will change due to normal network operations. If the implementation date is more than three months from the original report date, please request an updated report. • For the most accurate report, provider name, TIN/NPI, city, state, ZIP code, provider type/specialty are required (par/non par indicator and claims dollars are preferred). • Estimated turnaround: Seven business days.	
Current Procedural Terminology (CPT) analysis	CPT analysis provides average discounts by CPT codes in a given area. • Estimated turnaround: Three business days	
Request for proposal (RFP) responses	Cigna provides RFP/questionnaire support, as needed. • Estimated turnaround: 10 business days.	
Discount analysis	Employee census containing ZIP codes. • Estimated turnaround: Three business days.	
Getting started		
Eligible members	Network cannot be offered to members who have Medicare as their primary coverage. Network can only be used for medical plan coverage (i.e., no auto, workers' compensation plans).	
Implementation	New payer implementation takes an average of 90 days; new clients take 30 days. Implementation begins once contract and confidentiality agreements are signed.	
ID cards	All ID cards are printed and distributed by payer, and must follow Cigna ID card guidelines. All ID cards must be approved by Cigna prior to being distributed. In certain geographic areas, TPV logos are required.	
Summary plan description	Payer must submit summary plan descriptions for each customer to Cigna upon implementation, and upon renewal if benefits have changed.	
Benefit design requirements	Lifetime maximum	No lifetime maximum allowed.
	Benefit differential	There must be a minimum of a 10% benefit differential between in- and out-of-network coinsurance. A benefit differential is not required for Emergency Room/Urgent Care, Ambulance and Well Care/Preventive Care.
	Coinsurance	A minimum of 70% in-network coinsurance is required.
	Exclusivity	Cigna's PPO network is the sole network offered to client. Payer cannot apply other discounts to Cigna providers, or "cherry pick" discounts from another network while the Cigna network is in place within the Cigna network area.
	Exclusions, limitations	Scheduled benefit plans not permitted. Client Specific Networks (CSN) not permitted. Health system networks not permitted.

Technical specifications		
Product features		
National network breadth	The network represents more than 840,000 health care professionals and more than 6,400 facilities, and includes access to third-party vendors in certain areas.	
Transplant services	Services are managed by Cigna LifeSOURCE® Transplant Network (for more information see the LifeSOURCE At A Glance).	
Utilization Management	Services must be performed by Cigna; includes precertification/preauthorization, concurrent care, discharge planning, authorization extract files and medical necessity appeals.	
Case Management	Case Management services, provided by Cigna nurses, can be selected as part of Cigna's PPO network product for additional fees.	
Technical solutions		
Eligibility data exchange	Eligibility file required for priced claims, utilization management, case management and LifeSOURCE.	
Paid claim data	Payer to provide Cigna with paid claim data monthly, in an electronic format acceptable to Cigna.	
Electronic claim submission requirement	The Cigna Electronic Data Interchange (EDI) (62308) routing code must be used for claim submissions. Alternate EDI routing codes are not supported.	
Payer claim system access	Payer to provide Cigna with online, read-only access to payer's claim systems to address provider concerns and monitor compliance.	
Web tools	Find a health care professional directory	**myCigna.com** or **Cigna.com** Members can access an online network health care professional directory. Logon required. Members can access the unsecure network on Cigna.com by selecting the "PPO, Choice Fund PPO" network.
	Claim imaging	Authorized users can access paper claim image information online. Limit five users.
	Claim pricing	Authorized users can access paper claim pricing information online
	Service Request System (SRS)	Cigna provides an online tool for payers to submit operational questions and issues. Targeted response time is 48 business hours.
Service delivery		
Eligibility requirements	Retroactive termination of members cannot exceed 60 days and cannot be performed by omission.	
Service delivery performance reporting	Payer must agree to meet and report to Cigna on a monthly basis, certain basic metrics on calls and claims; reports should be sent to **PS_Scorecards@Cigna.com**.	
Claims	Claim submission	All claims are sent directly to Cigna. In cases where there are TPVs, Cigna will route to the appropriate TPV.
	Claim administration	Payers must have the flexibility to accommodate non-standard terms/provisions which will be provided by Cigna. 98% of Payer claims must be adjudicated within 18 days; 100% within 30 days.
	Quality standards	Payers must meet the following claim payment standards: • 95% claim payment accuracy • 90% claim processing accuracy • 99% financial accuracy
	Explanation of benefits	Members and providers must receive an explanation of benefits from payer with the required elements specified in the contract and approved by Cigna.
	Pended claims	Pended provider claims cannot exceed 90 days and must include some form of disposition communication to the provider (pay or deny, with appropriate remark code).
	Modifiers	Must follow Cigna medical reimbursement policy as it relates to modifiers/assistant surgeons. The policy takes priority over code review edits performed by the payer.

Technical specifications		
Claims (continued)	Timely filing	Payer must consider claims for benefits when submitted within 13 months from the date of service.
	Claim adjustments	Payer must adjust claims to reflect updated claim pricing within 15 calendar days of notification. Must comply with Cigna health care professional and health system contracts.
	Coordination Of Benefits (COB)	COB provisions to be applied by payer based on the client's plan.
	Overpayment recovery	Payer must notify providers in writing 30 days in advance of seeking recovery of an overpayment (except in cases of duplicate payment). If overpayment is due to retroactive termination, Payer can seek overpayment recovery from in-network providers up to 60 days from the date of service only.
	Retroactive terminations	Retroactive termination of members cannot exceed 60 days and cannot be performed by omission.
	Third-party recoveries	Payer is exclusively entitled to pursue the recovery of amounts paid to Cigna providers for claims that involve subrogation/right of recovery provisions, except where the provider agreement permits them to pursue a lien, subrogation or other recovery rights.
	Penalties	Payer is responsible for any penalties with respect to loss of discount for not meeting prompt pay contractual language.
Health care professional contractual requirements *(applies only to participating health care professionals)*	**Payers will abide by the provisions of Cigna provider contracts; specifically:**	
	Facility claims with no "lesser of" language	Cannot limit payments to billed charges when no "lesser of" language is present, e.g., Diagnosis Related Group (DRG).
	Auto-debiting for overpayment recovery	Overpayments made on claims cannot be auto-debited from the participating health care professional claim reimbursement.
	Prompt pay provisions	Must comply with prompt pay provisions, when applicable.
	Contracted rates	Providers must be paid their contracted rate, including specific scenarios covered by DRG or other methodologies, whereby the case rate payment may exceed the billed charge.
	Itemized bill request	Minimum dollar to request itemized bills is $75,000. Payer cannot hold or deny claims for itemized bill requests under $75,000.
	Auditing	Auditing network providers is not permitted. Audits can be performed on non-participating providers.
	Provider appeals	Pricing appeal timeframe varies by HCP. Typically less than 365 days.
	Implant services	Invoices cannot be required from participating hospitals and facilities.
Customer Service	Member customer service	Member services supported by payer.
	Eligibility verification	Payer to maintain a system for providers to verify eligibility of participants.
	Payer customer service support	Payers will provide phone support services to customers, members and providers regarding benefits, eligibility, claims status. All provider questions related to performance or contract interpretation to be forwarded to Cigna.
	Cigna provider call center services	Cigna metrics[1] include abandonment rates of less than 5% and average speed of answer less than 45 seconds.
	Provider look-up assistance	Online provider directory should be used. Call center support offered to a limited number of payer associates on an as-needed basis.

1. Measured through Payer-submitted scorecard

Technical specifications		
Appeals	Benefit appeals	The payer is responsible for all provider-related claim disputes in accordance with the terms of the benefit plan and/or eligibility. Questions, complaints, disputes and clinical appeals related to the performance or interpretation of a provider's contract or medical management determination must be forwarded to Cigna within four business days.
	Claim appeals	Payer is responsible for all member claim, benefit and eligibility with the exception of medical management appeals.
Billing and payment	Billing	Monthly self-billing.
	Payment amount	Payment is equal to the amount represented by the number of subscribers on the last day of the month for which payment is being made. Payment must be received by the 21st of the month immediately following the month for which payment is being made. Must supply supporting documentation that identifies the number of subscribers. Late payments may be subject to penalty charges.
	Nonpayment of group	Payer is responsible for payment.
Health care professional recruitment	Not available	
Reporting		
Customer reporting	Not provided.	
Fully insured reporting	Reporting supplied for required state and other administrative requirements.	
1099 production	1099s are provided from the claim administrator to the health care professional.	
Marketing & communication materials		
Branding	Use Cigna PPO for payer, client, and member communication. Provider-facing communications must include "Cigna PPO."	
Access marketing collateral	Overview of the network access capabilities available through Cigna payer solutions.	
Find a health care professional flyer	Overview of how to find a health care professional.	
External communications	All payer-created communications using the Cigna name, logo and/or network information must be approved by Cigna prior to use (examples: newsletters, payroll stuffers, website development, marketing materials).	

Optional services

In addition to the standard product services, the following optional services are available.

Service description		Pricing
Run-out services	Priced claim services following group termination. Run-out services to span 12 months following termination date. Pricing is four month Per Employee Per Month (PEPM). One time billing for run-out services at the time the group terminates and the run-out services begin.	Standard pricing is four months PEPM for 12 months of run-out services.
Re-implementation for payer model changes	Modifications that can be made to the core infrastructure of claims pricing following initial implementation based on a change within the payer's administrative practices.	Priced based on request.

Log in to the payer solutions website at **CignaPayerSolutions.com** for additional information, or email **CignaPayerSolutions@Cigna.com**.

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