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Introduction

On September 1, 2016, Seton Insurance Company will begin offering two new plans—Performance and Performance Plus. These new plans will be offered to Employers and employees in the Austin and Waco, Texas markets under the name “Seton Insurance Company.” These plans are being offered as part of a joint venture with Cigna, and will be administered by QualCare, a Cigna company. Throughout this manual you may see reference to Seton, Cigna, and QualCare.

What You’ll Find in this Manual

The Provider Manual contains Administrative Guidelines and Program Requirements for the programs, policies, rules, and procedures pertaining to Seton's insured or administered plans. Seton will give you advance notice of any material changes to the Administrative Guidelines and Program Requirements.

Your Seton Health Plan Network Services Agreement and this manual describe many of the terms under which you agree to provide services to Seton Insurance Members. Those terms include the reimbursement rates applicable to Covered Services provided to Members. However, the actual benefits payable by a Payer for Covered Services provided to a Member in all cases is determined exclusively by the terms of the Payer’s Benefit Plan.

The Seton Insurance Difference

Local. The Seton and Providence teams live and work within the community we serve. Our service representatives and account management team are local too, and responsive to your service needs. We are your neighbors, friends and family. We know the people and places nearby that can help support your patient’s care. We strive to bring tools, resources and access to help improve the health of our community.

Truly integrated. Our participating doctors and hospitals know how to navigate the system. Care is connected so there is less back and forth for your patients. Health information is used effectively to make decisions across the continuum of care. The end result is coordinated, personalized care every time.

Quality care. We are dedicated to providing clinical excellence and a unique perspective on healthcare. As providers of both care and coverage, we keep more healthcare decisions where they belong – between patients and their doctors. We provide proactive, convenient support that considers your patient’s whole well-being: medical, emotional, and spiritual.

Cost control. We strive to support you to deliver the right care, at the right place, at the right time to help drive better outcomes and lower costs. We partner with you to help your patient’s achieve better health in a cost-effective manner.

Contact us

Please contact us if you have questions about the information in this manual, or our plans and programs.

Note

The term “health care professional” used throughout this manual is referred to as “provider”, “hospital”, or “group”, “you or your” in your participation agreement. The term “we” or “us” refers to Seton Insurance Company.
State-Specific Information

In some cases, state law requirements supersede the policies and procedures outlined in this manual.

Participating Service Areas

Bastrop, Bell, Bosque, Burnet, Coryell, Falls, Hamilton, Hays, Hill, Limestone, McLennan, Travis, and Williamson.
### Important Contact Information

Find the contact you need for information about your patients with Seton coverage.

Also refer to the Member’s ID card for information about call, claim, and service channels.

<table>
<thead>
<tr>
<th>If you want to:</th>
<th>Use the following:</th>
</tr>
</thead>
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<tr>
<td>Update your contact or demographic information</td>
<td><a href="mailto:shpproviderservices@seton.org">shpproviderservices@seton.org</a></td>
</tr>
<tr>
<td>Verify patient eligibility and benefits</td>
<td>1.844.883.2422</td>
</tr>
<tr>
<td>Submit claims (paper and electronic)</td>
<td>Seton Insurance Company</td>
</tr>
<tr>
<td></td>
<td>PO Box 1700</td>
</tr>
<tr>
<td></td>
<td>Piscataway, NJ 08855-1700</td>
</tr>
<tr>
<td>Check the status of a claim</td>
<td>1.844.883.2422 – automated interactive voice response (IVR)</td>
</tr>
<tr>
<td>Submit or inquire about a claim appeal or dispute</td>
<td>Seton Insurance Company</td>
</tr>
<tr>
<td></td>
<td>Attention: Administrative Appeals</td>
</tr>
<tr>
<td></td>
<td>PO Box 1700</td>
</tr>
<tr>
<td></td>
<td>Piscataway, NJ 08855-1700</td>
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<td>Utilization Management appeals:</td>
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<td></td>
<td>Seton Appeals</td>
</tr>
<tr>
<td></td>
<td>PO Box 760</td>
</tr>
<tr>
<td></td>
<td>Piscataway, NJ 08855-0760</td>
</tr>
<tr>
<td>Request pharmacy prior authorization</td>
<td>Cigna Pharmacy: 1.800.592.5108</td>
</tr>
<tr>
<td>Request precertification for inpatient and outpatient services</td>
<td>1.844.883.2422</td>
</tr>
<tr>
<td>Request precertification for high-technology radiology and diagnostic cardiology</td>
<td>eviCore healthcare</td>
</tr>
<tr>
<td></td>
<td>myportal.MedSolutions.com</td>
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<tr>
<td>Call Provider Service or Customer Service</td>
<td>1.844.883.2422</td>
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<tr>
<td>Obtain a behavioral health referral</td>
<td>1.800.926.2273</td>
</tr>
<tr>
<td>ASHN (Chiro, PT, OT)</td>
<td>1.800.972.4226</td>
</tr>
<tr>
<td>Submit or inquire about health care professional credentialing</td>
<td><a href="mailto:SHPProviderServices@seton.org">SHPProviderServices@seton.org</a></td>
</tr>
<tr>
<td>View health care professional directories</td>
<td>Seton website: mySetonInsurance.com</td>
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Demographic Information and Directories

We use your demographic information to:

- Publish online provider directories
- Send communications to health care professionals
- Process claims

Contact shpproviderservices@seton.org for any changes to Provider’s address, telephone number, group affiliation, and other demographic updates.
## Our Products

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<th>Seton Insurance Company Products</th>
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<td><strong>Performance EPO</strong></td>
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<tr>
<td><strong>Performance Plus PPO</strong></td>
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</table>

| Service area | Bastrop, Bell, Bosque, Burnet, Coryell, Falls, Hamilton, Hays, Hill, Limestone, McLennan, Travis, and Williamson |
| License | Seton Insurance Company and Cigna Health & Life Insurance Co. |
| Product Type | Exclusive Provider Organization (EPO) | Preferred Provider Organization (PPO) |
| Referrals | No Referrals Required | No Referrals Required |
| HRA/HSA compatible | Yes | Yes |
| Out of Network Benefits | None, except emergency care | None, except emergency care |
| Network Tiering | 2 Tiers, Tiered Facility Benefits | 3 Tiers, Tiered Facility Benefits |

Our plans are most cost efficient for members when preferred hospitals (including affiliated hospitals of an acute hospital) are used for inpatient and outpatient services. If other facilities are chosen, patients will be responsible for a larger share of the cost. Members should consider where a physician has hospital admitting privileges before selecting a primary care physician or specialist. To determine the tier of a network hospital, go to [www.MySetonInsurance.com/providers](http://www.MySetonInsurance.com/providers).

**Network Description**

**Tier 1 (in network)**
- Seton and Providence Physician and hospital network with some Cigna providers
- Cigna Behavioral Health supplemented by Seton’s Behavioral Providers
- Cigna National Ancillaries
- LifeSource Transplant services

**Tier 2 (in network)**
Selected non-Seton facilities

**Tier 3 (out of network – PPO coverage only)**

| Pharmacy | Cigna Pharmacy |
| Behavioral health | Cigna Behavioral Health |
| PCP Selection | Not Required |
| Plan Designs | Select, Value and Saver, Flexible Benefit – Copay/Coinsurance, HDHP |
| Away from home care | Cigna Open Access Plus (OAP)/Shared Administration (SAR) Network outside of the service area |
| Medical Utilization & Case Management | Seton and Cigna |
| | Access to OON providers, Emergency Services |
We offer Performance (EPO) and Performance Plus (PPO) health plans. Both provide local quality, choice and convenience for our members, and include referral-free access and flexible plan options.

**Performance (EPO)**

In this product, members get access to quality, cost-effective care within their community. Aside from an emergency situation, members are covered when they use the Seton, Providence, and affiliated provider networks to receive care.

**Performance Plus (PPO)**

The Performance Plus plan gives members the same integrated network and benefit design as the Performance plan with the added flexibility of more provider choice through out-of-network coverage. Members will be responsible for more cost sharing through higher deductibles and coinsurance when they receive out-of-network care.

- **Select Plans**
  Offer a premier level of coverage with the freedom to use any provider in the network. Plans include a variety of deductible and coinsurance options to meet member needs.

- **Value Plans**
  For a lower premium option, the Value Plans offer the same deductible and coinsurance percentage options as Select plans, however the Value Plans will have a higher copay and out-of-pocket maximum.

- **Saver Plans**
  Saver plans are HSA qualified high-deductible health plans that allow members to save for future healthcare needs via a tax-advantaged health savings account or health reimbursement account.

**ID Cards – Quick Guide**

The Seton Insurance Company ID card includes information on the funding, insured or self-funded (ASO), of the member’s plan. If the member is covered by an insured Texas plan, the letters DOI appear on the front of the ID card. The letters appear in the lower left corner or on the upper right corner of the ID card.

If the letters DOI do not appear on the front of the ID card, then the member is in a self-funded (ASO) plan or and many of the Texas state requirements (such as prompt pay) do not apply to that member.

Included in this manual are front and back copies of the sample ID cards.
Performance (EPO)

Performance Plus (PPO)
eServices for Health Care Professionals

We want to help you make the most of your time, so we provide convenient tools to handle the administrative details of healthcare.

Use our eService tools to access the information you need – when you need it.

### Quick Summary of Key Tools

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<td><strong><a href="https://navinet.navimedix.com">https://navinet.navimedix.com</a></strong></td>
<td>This site offers secure, easy, and convenient access to eligibility, benefits and claims status information, precertification inquiry and submission, forms, policies and procedures.</td>
</tr>
<tr>
<td><strong>Cost of Care Estimator Tool</strong></td>
<td>Provides personalized estimates of the amount your patients will owe for specific medical and behavioral services. Helps facilitate financial discussions between you and your patients in Seton-administered or insured medical and behavioral plans to make payment arrangements before treatment. Helps your patients understand their financial obligation, increasing the potential for payment of out of pocket expenses. The printed Explanation of Estimate clearly illustrates “the math” and helps educate your patients on what they may owe for their Seton medical and behavioral benefits. Available on the secure: <a href="https://navinet.navimedix.com">https://navinet.navimedix.com</a> The tool can be used for your patients enrolled in any of these Seton-administered plans: Preferred Provider Organization (PPO) Exclusive Provider Organization (EPO)</td>
</tr>
<tr>
<td><strong>Electronic Data Interchange (EDI)</strong></td>
<td>EDI links your computer or practice management system with Seton’s systems, as well as with other health plans and government payers, to exchange health care information. You can submit claims, access eligibility, benefits and claim status information, submit precertification requests, or obtain an electronic remittance advice (ERA).</td>
</tr>
<tr>
<td><strong>Electronic Funds Transfer (EFT)</strong></td>
<td>EFT, also known as direct deposit, offers a secure method for funds to be deposited directly into your bank account for fee-for-service and capitated payments. Reimbursement payments are available the same day the deposit is electronically transferred to your bank account.</td>
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<td><strong>Online Remittance Reports</strong></td>
<td>If you are enrolled to receive payments using electronic funds transfer (EFT), you can: Look up a remittance report using various search options View each claim within the deposit, including the service line detail, paid amount, and patient responsibility amounts Search within the remittance report for specific patients or claims Access to remittance reports is available on the ChangeHealthcare.com website.</td>
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<tr>
<td><strong>Interactive Voice Response</strong></td>
<td>This interactive voice response telephone system provides access to eligibility, benefit and claims status information, precertification information, credentialing status, and more. 1.844.883.2422</td>
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Health Care Professionals Website - Navinet

The Health Care Professionals website [https://navinet.navimedix.com](https://navinet.navimedix.com) has been designed with YOU in mind—to fit your needs and the way you work.

It provides secure, 24/7 access to member and claim information, and includes features like auto-save and flagging that save you time and keystrokes.

### On Navinet you can access:

| Eligibility and Benefits | Obtain specific information about your patients covered by a Seton plan  
|                         | View coinsurance, deductibles, and plan maximums  
| Estimate Your Patient’s Out-of-Pocket Costs | Determine the total cost of a medical or behavioral service or treatment  
|                        | Estimates how much Seton will pay for a service or treatment  
|                        | Provide an estimate of what your patient will owe out-of-pocket  
| Online Precertification | View the status of requests made by phone, fax, or online (Seton members)  
|                        | Get an immediate response to your request (Seton members)  
|                        | Learn if precertification is required for your patient covered by a Seton medical plan  
| Claim Information      | View claim status:  
|                        | View service line details for each claim including amount not covered, coinsurance, patient responsibility, and service line remark codes  
|                        | View payment information, including claim paid amount, check number, date issued, payment method, and payment date  

### To register and begin using the Navinet website:

1. Go to [https://navinet.navimedix.com](https://navinet.navimedix.com)
2. Click “Register Now”
3. Follow the registration process

### Online Precertification Using NaviNet

Using our online precertification tool can help you spend less time on the phone or printing and faxing paperwork.

### Get answersfast

- Learn if precertification is required for a covered medical service
Online Remittance Reports

If you are enrolled to receive payments from Seton using electronic funds transfer (EFT) you can access remittance reports online that explain your processed claims, direct deposit activity reports (DDARs), or checkless explanations of payment (EOPs).

The Remittance Reports search tool allows you to:

- View your remittance reports online the same day you receive your EFT
- Easily reconcile payments using a remittance tracking number on your EFT report, electronic remittance advice (ERA), or online remittance report
- Look up a remittance report using several options:
  - Deposit Amount: Search for a specific deposit amount or deposits made within a specific date range
  - Patient Information: Search for a specific patient
  - Claim/Reference Number
  - Remittance Tracking Number
- View each medical claim within the deposit, including the service line detail paid amount and patient responsibility.

If you are already registered for the ChangeHealthcare website and have access to claims status inquiry, you automatically have access to online remittance reports.

Primary Administrators: If you have staff that will need access to online remittance reports, log in to ChangeHealthcare.com for additional assistance.

If you are not yet registered for the website, go to ChangeHealthcare.com to register. Once you complete the registration information and it has been validated, you can access your remittance reports.

Cost of Care Estimator Tool

The Cigna Cost of Care Estimator is an electronic tool available through the secure Navinnet portal https://navinet.navimedix.com. The Estimator gives health care professionals the ability to create an estimate of their patient’s payment responsibility specific to that health care professional and the treatment or service. The estimate is based on a real-time snapshot of the member’s Cigna-administered benefits. This tool helps eliminate financial surprises by estimating the cost of the medical or behavioral service, highlighting the member’s anticipated payment responsibility, and providing you and your patients with an itemized, printable Explanation of Estimate. It is fast to use, easy to understand, and can be accessed at any time.

By entering the CPT code(s) or identifying information about the procedure along with the plan member’s Cigna identification number and date of birth, you will receive a personalized Explanation of Estimate that contains the following information:

- Total cost of the service
- Plan member’s deductible/coinsurance/copay responsibility
- Plan member’s estimated amount owed out-of-pocket

The estimate you receive represents your patient’s anticipated out-of-pocket expense if the services billed are covered under their medical insurance plan. It does not guarantee coverage or payment, but allows you to have a financial discussion with your patient and set realistic financial obligations for them.
Electronic Data Interchange (EDI)

EDI allows patient information to be transferred between you and Seton in a standardized, secure way, and makes it available right on your desktop.

Use your existing EDI vendor, practice management software, or account receivable software to connect with our systems to:

1. Submit electronic claims to Seton (837), including coordination of benefit (COB) claims, and receive an electronic claim acknowledgment.
2. Receive payment information in the electronic remittance advice, including the amount paid and when the check or electronic funds transfer (EFT) was issued.

Payor ID for Submitting Electronic Claims

<table>
<thead>
<tr>
<th>Payer ID</th>
<th>Claim type</th>
</tr>
</thead>
<tbody>
<tr>
<td>22312</td>
<td>Seton medical plan and behavioral claims.</td>
</tr>
</tbody>
</table>

*Both primary and secondary (COB) claims can be submitted electronically to Seton.

Seton Toll-Free Telephone Numbers

- 1.844.883.2422 – for your patients with Seton ID cards

The above number offers quick access to eligibility, benefit, and claim information. You may use our interactive voice response (IVR) automated telephone system anytime or speak to a Seton Customer Service Representative Monday through Friday, 6 a.m. to 6 p.m. and Saturdays 9 a.m. to 1 p.m. CST.

You can receive eligibility and benefit information for multiple patients during a single phone call. When using the IVR, you have the option of hearing the requested information or having it faxed to you.

You may also submit requests for precertification and referrals. Detailed claim information is available, such as claim status, payee, check amounts, and when and where payments were sent.
Health Care Professional Participation

In our role as a health service company, Seton contracts with physicians, physician groups, associations and delivery systems, hospitals, ancillary practitioners, and facilities so that our members can obtain the care they need at a more affordable cost—for both primary and specialty care. In most situations, our members expect to receive care from Seton-participating health care professionals in order to maximize their in-network benefits, even when their doctor refers them elsewhere.

As part of your contract upon joining the Seton network, you agree to refer your patients to other in-network contracted physicians, hospitals, and other health care professionals and facilities. Naturally, there are some exceptions; for example, in an emergency or if services cannot be provided within the network. It is Seton's expectation that you will partner with Seton members to help them maximize their benefits by referring additional care to other participating health care professionals.

As a participating health care professional, you must provide services with the same standard of care, skill and diligence customarily used by similar health care providers in your community, the requirements of applicable law, and the standards of applicable accreditation organizations. All services that are provided within the scope of your practice or license must be provided on a participating basis. Regardless of your physical location, all aspects of your practice are participating under the terms of your Seton service agreement, unless services are provided under the terms of another applicable Seton participation agreement or a contractual exception apply. Services you provide to Seton members should be done in the same manner, under the same standards, and with the same time availability as offered to other patients. You will not differentiate or discriminate in the treatment of any Seton member based on race, color, national origin, ancestry, religion, sex, transgender, marital status, sexual orientation, age, health status, veteran's status, handicap or source of payment.

Further, as a participating health care professional, you must meet the Seton 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 members and cooperating with Seton administrative, quality, and medical management programs. Seton evaluates performance data for quality improvement activities, preferred status designation in Seton's network, and reduced member cost sharing, as applicable.

Primary Care Physician (PCP) Services

The PCP coordinates care for members who choose a PCP. Coordinating a member’s care can include providing treatment, referring to participating specialists or other health care professionals, and requesting precertification of coverage.

A PCP may practice in the field of family practice, general medicine, internal medicine, or pediatrics. Other specialties may be designated as PCPs depending upon state laws. For managed care plans, members are required or encouraged to select a PCP to manage their healthcare needs.

PCPs must comply with Seton medical management programs, including utilization management, quality management, preventive care guidelines, and prescription drug programs.
Specialty Care Physician (SCP) Services

The SCP provides specialty medical services to members with Seton coverage referred by a PCP or selected by the member in accordance with plan benefits.

An SCP coordinates the Seton member’s care with the PCP to ensure compliance with Seton’s medical management requirements. This includes verifying referrals or precertification requirements before treating members (if applicable) and communicating findings and treatment plans to the PCP on a timely basis.

An SCP accepts referred members from participating health care professionals and renders services as appropriate. The SCP must comply with Seton medical management programs, including utilization management, quality management, and prescription drug programs.

Service Standards and Requirements

Members in Seton-administered or insured plans expect quality healthcare services. You can assist us in maintaining quality service by adhering to the following standards and requirements. Compliance with these standards may be monitored through site visits, medical record reviews, and member surveys.

Acceptance and Transfer of Members

You should not refuse or fail to provide services to any member unless you are incapable of providing the necessary services or as otherwise provided in the Closing a Panel section that follows. You are expected to provide services to members in the same manner, in accordance with the same standards, and with the same time availability as provided to other patients.

Communication to Members of Professional Termination

If your participation with Seton is terminated entirely or with respect to any of our benefit plan types, only Seton will notify affected members of the termination to the extent required by applicable law and applicable accrediting requirements. Such notification will occur before the effective date of the termination unless Seton does not receive sufficient advance notice. In this instance, Seton will notify affected members to the extent required as soon as reasonably possible. Upon request, you are responsible for providing a listing of members affected by your termination within seven business days of the date of the notice of termination.

Office Hours and Accessibility

Members must have access to medical care within a reasonable length of time.

You must have scheduled office hours for at least 24 hours per week. PCPs and SCPs must be available to provide services to members 24 hours per day every day of the year. Best efforts must be made to ensure a Seton participating health care professional is on call and available when the office is closed.

There must be a publicized telephone number for members 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. Refer to Telephone Response Time section below.

Access

Outpatient Diagnostic Hours

Hospitals and ancillary facilities must have scheduled outpatient hours for routine diagnostic and supplemental services, including clinical laboratory, radiology and physical medicine, as
applicable under the provider agreement.

**Hospital Hours**
Hospitals must provide or arrange for necessary medical services 24 hours a day, seven days a week.

**Telephone Response Time**
Telephone calls must be answered promptly. When it is necessary to place callers on hold, callers should be asked if they can hold and the caller should only be placed on hold after giving an affirmative response. Callers who do not wish to hold should have their calls handled as appropriate. If the phone is answered by an answering machine, the message must give emergency instructions.

**Appointments and Scheduling Guidelines**
- You should ensure members have access to timely appointments and scheduling.
- Emergent or high-risk cases should have access to immediate appointments, appropriate emergency room authorization or direction to dial 911.
- Urgent cases should have access to appointments within 24 hours.
- Non-urgent, symptomatic or routine appointments should be scheduled within seven to 14 days.
- Preventive screenings and physicals should be scheduled within 30 days.
- Generally, obstetric prenatal care for non-high risk and non-urgent situations should be provided within 14 days in the first trimester, within seven days in the second trimester and three days in the third trimester.

**Professional Services**
All services must be provided by duly licensed, certified or otherwise authorized professional personnel and at facilities that comply with:
- Generally accepted medical and surgical practices
- State and federal law
- Accreditation organization standards

**Cooperation with Programs**
Seton is committed to promoting access to quality services for members. To support this commitment, we require your cooperation with Seton programs, including administrative programs such as claim appeals, wellness, and other medical management programs.

Cooperation with Seton in establishing and implementing policies and programs to comply with regulatory, contractual or certification requirements of Healthcare Effectiveness Data and Information Set (HEDIS®), National Committee for Quality Assurance (NCQA), and any other applicable accreditation organization is equally important.

**Member Billing**

**Copayments:** A copayment is a fixed dollar amount that a member pays per service. Copayment amounts are printed on the Seton ID card. Collect the applicable copayment amounts on the ID card at the time of service.

**Coinsurance & Deductibles:** For members with plans that have deductibles or require members to pay a percentage of the covered charges (coinsurance) after satisfying any deductible amount, you should submit claims to Seton or its designee and receive an explanation of payment (EOP) indicating the members' responsibility before billing patients. Coinsurance and deductibles should not be collected at the time of service unless you obtain
an estimate of the deductible and coinsurance obligations of the plan member, and provided a copy of the estimate to the member at the time of service.

Note: If fee schedule is unavailable, contact Customer Service for coinsurance estimate. Providers should not collect until estimates are available.

**Denied Payment and Member Non-Liability**

You cannot bill members for covered services or for services for which payment was denied due to your failure to comply with your provider agreement or Administrative Guidelines and Program Requirements, including Seton utilization management requirements and timely filing requirements.

**Confidentiality**

Seton maintains strict policies to protect confidential information. As a participating health care professional, you are responsible for maintaining the confidentiality of member 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 Seton policies, call 1.844.883.2422.

**Referrals to Non-Participating Health Care Professionals and Facilities, including Ambulatory Surgical Centers, Dialysis Facilities and Free Standing Laboratories**

Patients with Seton coverage generally expect and prefer that their Seton participating physician help them use their in-network benefits whenever possible. When referred to a non-participating health care professional, facility or other health care entity, the patient may incur unexpected out of pocket costs.

Patients with Seton coverage may choose to use their out-of-network benefits following a discussion with their physician. To help ensure that patients are making informed choices regarding the use of participating or non-participating health care professional services or facilities, they should be provided meaningful information about the potential financial impact of such choices, in-network alternatives, and the referring physician’s financial interest, if any, should a non-network alternative be chosen.

Seton participating health care professionals, facilities and other health care entities should have at least one Seton participating choice for the services typically referred. Participating health care professionals, facilities and other health care entities can be found on the Seton physician website at [www.setoninsurance.com](http://www.setoninsurance.com).

**Medical Records**

**This information pertains to hospitals and ancillary facilities only.**

Seton safeguards member information and expects the same standard of you. To maintain confidentiality and privacy of member Protected Health Information (PHI) and Personally Identifiable Information (PII), you must keep secure, accurate, and organized medical records for each patient and comply with applicable federal and state law about such records.
You must allow Seton personnel access to member medical records as appropriate for business purposes during normal business hours, including medical chart reviews. At the time of service, you must request that members sign a routine consent form allowing for the disclosures required under the provider agreement, these Administrative Guidelines, and Program Requirements to the extent such consent or approval is required by law.

Medical Record Reviews
This information pertains to physicians and other health care professionals only.

Physicians plan patient care and provide continuous information about the patient’s medical treatment using the patient’s medical records. As a permanent record, the patient’s medical record informs other health care professionals about the patient’s medical history.

Medical Record Documentation: To help ensure members receive effective, safe, and confidential patient care, medical records should be current, detailed, organized, and signed. Health Care Professionals are asked to attest to the adherence of confidentiality practices around secure storage of medical records, access to records only by authorized personnel, and periodic training of staff in member information confidentiality. Records should, at a minimum, document these core elements:

- Updated, complete problem list or summary of health maintenance exams
- Current prescription medication list or medication notes
- Review of consultant report, if requested
- Medical history
- Visit exam coinciding with chief complaint
- Documentation of treatment plan
- Review of lab and diagnostic studies
- Notation of each follow-up visit
- Allergies and adverse reactions to medication
- Follow up on prior problem addressed at each visit

Note: It is important that all medical conditions are clinically supported and indicate treatment. Seton is required to provide requested medical records as evidence of conditions and the treatment to the Centers for Medicare & Medicaid (CMS) as part of our risk adjustment program.

Physicians should ask patients if they have executed an advance directive declaration (living will or healthcare power of attorney) and document the response on their medical record.

You must allow Seton personnel, or Seton's designee, access to members’ medical records for appropriate Seton business purposes during normal business hours, including medical chart review. At the time of service, you must request that members sign a routine consent form allowing for the disclosures required under the provider agreement, these Administrative Guidelines and Program Requirements to the extent such consent or authorization is required by law.
Credentialing

Credentialing for Physicians and Health Care Professionals

Health care professionals are credentialled before becoming a Seton participating provider and are recredentialled periodically thereafter, to help ensure they continue to meet our qualifications for participation. Criteria for participation are determined by business needs and by our credentialing policies and procedures, reviewed annually to reflect National Committee for Quality Assurance (NCQA), local and state standards.

Follow these steps to complete the credentialing process:

To request participation contact Seton at SHPProviderServices@seton.org

All new provider requests are reviewed by the Seton Network Oversight Committee (NOC).

In order to be considered, please include the following in your letter of interest:

- Specialty
- Office Location or Service area by county
- Resume (if Mental Health)

Upon NOC approval, submit the following credentialing documents:

- Completed and signed Texas Standard Credentialing Application (must be 1/07 version; signed and dated on pages 11&12 within the last 6 months)
- Malpractice certificate (facesheet)
- Applicable Licenses (i.e. Texas Medical License, DEA, DPS, etc)
- Proof of Board Certification
- Letter of recommendation from supervising physician (if applicable)
- Signed collaborative protocol agreement (if applicable)
- Signed Network Services Agreement
- Current W-9

Once all documents are received, the complete packet will be submitted to Credentialing. If any information is missing, you will be contacted by the Credentialing Coordinator. The Credentialing process may take 30 to 90 days to complete. During the credentialing process you have the following rights:

- The right to review information submitted to support your credentialing application.
- The right to correct erroneous information within 10 business days of notification by the Credentialing Coordinator. Corrections must be submitted in writing, via email or fax.
- The right to be informed of the status of your re-credentialing application upon request.
- The right to be notified of these rights.

Once approved, you will be notified of your effective date with the Seton Insurance Company.

Notice of Material Changes

As a participating health care professional, you are responsible for notifying Seton immediately of any material changes to the information presented as part of the credentialing or recredentialing process. Failure to notify Seton of changes or to satisfy requirements may result in your removal from Seton Insurance Company.
**Recredentialing Process**

Seton recredentials Practitioners by re-evaluating their qualifications at least every three years, but may evaluate the appropriateness of credentials for any Practitioner more frequently when required by a change in relevant information or if the Credentialing Committee makes such a recommendation. The three-year credentialing cycle begins with the date of the initial credentialing decision.

Six months prior to the Practitioner’s recredentialing date, the Seton Credentialing Coordinator sends the Practitioner correspondence via email, fax or postal mail, requesting an update of the information contained in the original application. Also included is a cover letter notifying practitioners of their right to:

1. Review information submitted to support their re-credentialing application, including the:
   a. Name and telephone number of the credentialing staff to contact to make arrangements to review the information.
2. Correct erroneous information including the:
   a. Time frame for changes.
   b. Format for submitting corrections.
   c. Person to whom corrections must be submitted.
3. Obtain information about the status of their re-credentialing application including the name and telephone number of the person to contact.

If the updated application is not received three months prior to the recredentialing date, a second notice is sent to the Practitioner. A final notice is sent to the Practitioner thirty (30) business days prior to the Credentialing Committee meeting. Practitioners who do not return the updated application within 10 business days prior to the Credentialing Committee meeting will not be considered for recredentialing. The Practitioner will be notified in writing via certified mail in such event.

**Non-Physician Practitioners**

Seton credentials and recredentials non-physician practitioners in the following categories when Seton holds a direct provider agreement with the practitioner:

| Certified Midwives and Certified Nurse Midwives | Certified Registered Nurse Anesthetists | Non-Physician Acupuncturists |
| Naturopaths | Nurse Practitioners | Occupational Therapists |
| Physician Assistants | Physical Therapists | Speech Therapists |

This list is subject to change and is subject to state law. Credentialing and recredentialing requirements are similar to physician requirements.

**Credentialing and Recredentialing for Hospitals and Ancillary Facilities**

Each Entity must meet the following criteria to be considered for credentialing or recredentialing:

1. Current required license(s). A current copy of each license applicable to the Entity will be retained in the file.
2. Insurance. The Entity must maintain errors and omissions (malpractice) insurance for at least the required “per occurrence” and aggregate limits. A current copy of liability coverage will be retained in the file.
   a. Medicare/Medicaid Program Participation Eligibility. The Entity must not be ineligible, excluded, suspended, revoked, involuntarily terminated or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, and must be without any, conditions, restrictions or sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS or State Medical or Pharmacy Boards and must not participate in the Medicare Opt Out program. SHP will verify reported sanction information from an NCQA approved source.
   b. Appropriate Accreditation or Satisfactory Alternative.

Accreditation from one or more of the following agencies:
- Joint Commission of Accreditation of Healthcare Organizations (Joint Commission)
- American Association for Accreditation of Ambulatory Plastic Surgery Centers
- Accreditation Association for Ambulatory Health Care, Inc.
- Accreditation Association for Podiatric Surgical Facilities
- American Lithotripsy Society
- American College of Radiology for Freestanding Radiology Facilities
- Clinical Laboratory Improvement Amendments
- Comprehensive Outpatient Rehabilitation Facility

Seton Insurance Company must obtain a copy of the accreditation report.

Exceptions to approval by a recognized accrediting body can be granted by the Credentialing Committee for Hospitals, Home Health Agencies, and Skilled Nursing Facilities if the following criteria are met:

1. An onsite quality assessment performed (A CMS site review report is an acceptable substitution to a site visit).
   AND

2. The entity is located in a medically underserved county.
   OR

3. Provider Relations Director documents and presents the reason for needing the non-accredited facility to the Credentialing Committee.

All credentialing information must be current within 180 calendar days at the time of the Credentialing Committee review. Site Reviews, if necessary for an exception to the accreditation requirement, are valid for one year.

Entities will be re-credentialed at least every 36 months. Participating Entities must complete an application in a timely manner.
Eligibility

Determining Eligibility

It is important to determine patient eligibility prior to rendering service. We recommend verifying your patient’s eligibility prior to their appointment date. Patients are responsible for presenting their ID card or enrollment form (if they are awaiting receipt of an ID card) as proof of coverage.

Eligibility Verification

In addition to viewing your patient’s ID card, you should verify eligibility by:

- Accessing our website https://navinet.navimedix.com
- Using our automated interactive voice response (IVR) system
- Contacting a Seton Customer Service Representative

<table>
<thead>
<tr>
<th>When verifying eligibility and benefit information on the website you can receive:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility status (active, inactive, non-covered)</td>
</tr>
<tr>
<td>Coverage effective and term dates</td>
</tr>
<tr>
<td>Patient insurance and plan types such as PPO and EPO</td>
</tr>
<tr>
<td>Plan level copayment, coinsurance, and deductible</td>
</tr>
<tr>
<td>Benefit-specific copayment, coinsurance, and deductible amounts</td>
</tr>
<tr>
<td>An indicator of different benefits for in-network and out-of-network</td>
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<tr>
<td>Primary care physician (PCP), if one has been selected</td>
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</tbody>
</table>
Medical Management Program

Medical Management Model

Our medical management solution is at the center of our innovative approach to health care benefits. This model includes prospective, concurrent, and retrospective reviews, as well as case management services.

- Precertification of coverage is required for all non-obstetric and non-emergent inpatient admissions, including rehabilitation, skilled nursing facilities, hospice, and long term care facilities. Precertification of coverage is also required for all admissions from the emergency department with notification provided within one business day of the admission unless otherwise required by state law, reasonably precluded by clinical situation, or member presentation of other coverage documentation.
- Inpatient case management (continued stay review) generally begins on the first day of hospitalization, or on the approved MCG length-of-stay minus one day.
- Nurses can provide telephone, on-site inpatient case management, as well as referrals to ongoing case management for members post-discharge, if appropriate.
- Precertification of coverage is required for certain selected outpatient services.

Precertification Protocol

Our precertification program helps you determine if your patients’ care will be covered under their benefit plan. The precertification process also helps direct members to various support programs, such as wellness coaching, chronic condition coaching, and case management.

In an effort to support accurate coverage determinations and access to quality care for plan members, we continually review our precertification process and requirements. Updates include additions and removals based on our standard coverage policy review process, as well as new Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes that require precertification. We may make additional changes to the precertification requirements, as needed.

Utilization Management – Responsibility for Precertification

To accomplish these goals, we require that referring (ordering or admitting) physicians request and obtain precertification for certain in-network services. The rendering facility or health care professional is responsible for validating that precertification has been obtained for all elective (i.e., non-emergent or non-urgent) services prior to performing the service for patients whose benefit plans require precertification.

Precertification of coverage determinations are based upon the patient’s eligibility, the specific terms of the applicable benefit plan, internal or external clinical coverage guidelines, and the patient’s particular circumstances.

Failure to obtain precertification may result in an administrative denial of payment. For more information, please see the specific requirements in the following sections.

Utilization Management – Precertification of Inpatient Admissions

Precertification for all planned inpatient non-obstetrical admissions is required.
We review certain procedures to establish medical necessity, confirm that the proposed length of stay is appropriate, and determine if the requested services are covered benefits.

**Obstetric (Maternity) Admissions**

Obstetric admissions that result in a length of stay of not more than 48 hours after vaginal deliveries or not more than 96 hours after Cesarean deliveries do not require precertification. These admissions are referred to as “pre-qualified maternity stays.” However, please note that precertification is required for obstetric admissions that extend beyond 48 hours following vaginal deliveries or 96 hours following Cesarean deliveries.

**Emergency Services**

Precertification is not required for emergency services. However, emergency services that result in an inpatient hospital admission must be reported within one business day of the admission unless dictated otherwise by state mandate or reasonably precluded by clinical situation or member presentation of other coverage documentation.

The following information is typically required for precertification:

- Member name and ID number
- Member date of birth
- Diagnosis including ICD-10-CM if available
- Requesting or referring health care professional
- Servicing health care professional, vendor, or facility
- Pertinent medical history and justification for service
- Date of injury (if applicable)
- Anticipated length of stay for inpatient stays
- Date of request
- Additional insurance coverage (if applicable)
- Place of service and level of care (inpatient and outpatient)
- Description and code, if available, for procedure, service, or item to be precertified (CPT-4 or HCPCS)

**Precertification Requirements**

You can verify precertification requirements [https://navinet.navimedix.com](https://navinet.navimedix.com) or by calling the telephone number on the member’s ID card.

Please note the following:

- Precertification is required at least two business days prior to the admission date for all elective, inpatient admissions unless mandated otherwise by applicable federal or state law.
- All urgent and emergent admissions, including observation admissions require notification within one business day of the inpatient admission unless mandated otherwise by state law or reasonably precluded by clinical situation or member presentation of other coverage documentation.
- Precertification is required for all anesthesia and facility charges that are provided for non-covered dental care and for elective admission to other inpatient facilities such as skilled nursing facilities, inpatient hospices, and rehabilitation centers.
Utilization Management – Precertification of Outpatient Services

Selected outpatient surgeries, procedures, and services must be precertified.

Please note that we will deny reimbursement for outpatient services that require precertification if precertification was not requested. This is true regardless of medical necessity, unless the facility or health care professional can demonstrate, upon appeal that the services were performed on an emergency basis or that extenuating circumstances prevented precertification.

Outpatient surgery rates include all post-operative care required within the first 23 hours post-procedure, including recovery room care and observation. Therefore, precertification of coverage is not required for post-operative care, but is required if a member needs to be admitted as an inpatient.

All other outpatient services that require precertification, but that are performed without obtaining precertification, will be denied. This does not include services that have extenuating circumstances or those services that are performed in an emergency room. In these cases, an appeal may be needed to show that the service was urgent or emergent. If the appeal documents this successfully, then the service will be reviewed clinically for coverage.

Extenuating Circumstances

Extenuating circumstances are factors beyond the control of the rendering health care professional or facility that make it impractical to obtain or validate the existence of a precertification of coverage prior to rendering the service (e.g., natural disaster or incorrect insurance information).

Additionally, emergency and urgent care services that are performed in the emergency room do not require precertification, and will be considered at the in-network benefit level.

For emergency or urgent services that were not performed in the emergency room, the health care professional or facility must submit evidence of why the service or test was required within one business day (i.e., why the condition required prompt medical attention).

If payment is denied, but the services meets the “Emergent, Urgent, or Extenuating Circumstances” criteria (as outlined below), the health care professional or facility should submit proof and a copy of the Explanation of Payment (EOP) to the address on the back of the member’s ID card for review.

Evidence of Extenuating Circumstances

For evidence of extenuating circumstances, the health care professional or facility must submit an explanation of the extraordinary circumstances responsible for the failure to obtain precertification.

For example, in circumstances where the patient submitted the wrong insurance information, the health care professional or facility should submit documentation that shows the patient submitted the wrong insurance information (e.g., a copy of the member’s insurance card, note in office records, etc.). The denial decision will be upheld if the health care professional or facility only submits a medical record and not the explanation.

As a reminder, under the terms of your Seton Insurance provider agreement, you cannot bill Seton Insurance plan members for covered services that are denied due to failure to obtain precertification.
Outpatient Precertification List

The list of outpatient services requiring precertification of coverage is occasionally updated. The most current list of services requiring precertification can be accessed through the Navinet link.

The following is a partial list of outpatient services that **must be precertified**.

- Air ambulance
- Back and spine
- Cardioverter – Defibrillator Pulse Generators
- Cosmetic procedures
- Cardiac diagnostics & procedures
- Elective MRA, MRI, MRS, CT, and PET scans
- External prosthetic appliances (certain codes)
- Genetic testing
- Home infusion therapy
- Orthognathic procedures
- Neurostimulators
- Orthotics
- Potential experimental, investigational, and/or unproven treatments
- Procedures to treat injury to healthy natural teeth
- Seat lifts
- Sleep studies
- Special wheelchairs
- Speech therapy
- Therapeutic radiology
- Unlisted procedures
- Anesthesia and/or facility fees for non-covered dental services
- Insulin pumps
- Cochlear implants
- Dental implants
- Select injectable medications
- Electronic stimulation/transcutaneous electrical nerve stimulation (TENS)/osteogenesis stimulation
- Obesity surgery – inpatient or outpatient
- Home health care
- Implants
- New and emerging technologies
- Penile implants
- Power operated vehicles
- Radiation therapy
- Skin substitutes
- Specialty oxygen systems
- Speech generating devices
- Temporomandibular Joint Syndrome procedures (TMJ)
- Transplants
- Uvulopalatopharyngoplasty
- Varicose vein treatment

**General Considerations – Precertification: Inpatient or Outpatient Services**

Precertification is neither a guarantee of payment nor a guarantee that billed codes will not be considered incidental or mutually exclusive to other billed services. Coverage is subject to the terms of a member’s benefit plan and eligibility on the date of service.

We (or our designees) make coverage determinations in accordance with the timeframes required under applicable law. You must supply all information requested within the timeframes specified for us to make a precertification determination. Failure to provide information within the timeframes requested may result in non-payment.

If a precertification request is approved, a precertification number is assigned. Some situations may require a second precertification number, including:

- Transfer to another facility; or
- Transfer from an acute hospital bed to a rehabilitation, skilled nursing facility, or inpatient hospice bed within the same facility.
Our Coverage Policy Unit is responsible for the development of internal clinical guidelines, as well as for the proper use of externally developed guidelines (e.g., MCG). Our utilization management staff or delegates use these guidelines to assess the medical necessity of a treatment or procedure, determine coverage for an appropriate inpatient length of stay, or make other clinically-based coverage decisions.

Coverage for services is reviewed on a case-by-case basis. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the individual's benefit plan document – a group service agreement, evidence of coverage, certificate of coverage, Summary Plan Description (SPD), or similar document.

However, in order to facilitate accurate and consistent coverage determinations, we maintain certain collateral source information and product-specific tools that aid our staff in applying the terms of a benefit plan document to a particular benefit request.

Copies of the clinical coverage guidelines and references that are applied by us are available at https://navinet.navimedix.com.

**Reviewing Utilization Management and Coverage Decisions**

A Seton Insurance medical director is available to discuss utilization management issues and coverage determinations. This process, referred to as the “peer-to-peer review process,” gives you the opportunity to provide additional clinical information.

As a result of this process, a medical director may revise a previous coverage denial decision. However, if a peer-to-peer review does not result in a revised coverage decision, you may still request an appeal through the Seton Insurance appeal process.

Please note that we (and our delegated utilization review agents) do not reward the members involved in the medical necessity based coverage review process for issuing denials of coverage, nor do we provide them with financial incentives to deny coverage of medically necessary and appropriate care.

**Specialty Pharmacy Requirement**

We require the National Drug Code (NDC) number be included in addition to the Healthcare Common Procedure Coding System (HCPCS) code on some claims, when the individual’s health plan requires precertification. The list of specialty medications that are included in this requirement, details on which claims require the NDC number, information about where to include the NDC on the claim, and other additional information can be found at https://navinet.navimedix.com.

**Request for TX SB 418 Written Verification**

Services to fully insured individuals eligible for the TX SB 418 Written Verification process described in the Member Information Section also may require prior authorization. If prior authorization is required, the provider will receive the Seton Insurance standard coverage determination letter with a prior authorization number. Health Care Professionals will receive a separate letter with the TX SB 418 Verification/Declination Decision and a unique Verification/Declination number. The protocol for requesting a TX SB 418 Verification is outlined on Page 95 of this manual.
Physician Office Laboratory Tests

This information pertains to physicians and other health care professionals only.

Laboratory test procedures must be performed in a laboratory by you or your staff. You will only be reimbursed for covered services that you are certified to perform through the Clinical Laboratory Improvement Amendments (CLIA) program. All tests for laboratory procedures that you are not certified to perform through CLIA must be referred to a participating laboratory provider.

Please note that pass-through billing is not permitted for tests that are not performed by you. These tests may not be billed to Seton Insurance or any Seton Insurance affiliate, payer affiliate, payer, or member.

Inpatient Case Management (Continued Stay Review)

Under our inpatient case management (continued stay review) program, we (or our designee’s nurses or medical directors) review coverage for a patient’s hospital stay and facilitate discharge planning and post-hospitalization follow-up. As part of this, you are required to provide us (or our designee) access to certain information, including:

- Medical records that document a patient’s clinical status
- A treatment plan that is consistent with continued inpatient care
- Documentation that a patient’s condition cannot be managed safely at another level of care (e.g., skilled nursing facility, outpatient, or home), if applicable
- Discharge planning documentation

Non-Authorization of Benefits

This information pertains to hospitals and ancillary facilities only.

In certain cases, we may not authorize coverage of benefits for hospital admissions or continued hospitalization. Some examples include:

- When a hospital does not provide timely clinical information that substantiates medical necessity.
- When there are delays in services that prolong a patients’ length of stay. Delays include:
  - The unavailability of an operating or procedure room space
  - Rescheduling surgery or procedures for space-related reasons
  - Suboptimal planning, sequencing, or management of medical care or discharge arrangements
  - The failure to obtain necessary ancillary or diagnostic services
- Elective surgeries that are not performed on the day of admission, unless a preoperative day has been authorized.

Health care professionals can discuss a coverage denial decision with a medical director by initiating a peer-to-peer discussion. You can do this by calling 1.844.419.2534.

Case Management

We have many voluntary case management programs to serve your patients, including complex case management for members needing extra support on a short-term or long-term basis, and for catastrophic cases. We also have specialty case management programs for high
risk maternity members, oncology patients, transplant patients, and infants requiring neonatal intensive care unit (NICU) services.

Your participation in, and support of, our case management programs is critical to help meet our shared goal of achieving the best clinical outcomes for your patients. Our case managers are ready and available to support your treatment plans in order to help your patients understand the importance of adherence to your care protocols. Our focus is to help our members reach their health/medical goals, reduce preventable acute care (admissions, readmissions, and ER visits), and to identify and resolve potential gaps in care.

Our nurses can support your treatment plan by:

- Reviewing your treatment plan with the patient/caregiver by telephone, or in person, to help ensure the patient understands how to use their medications.
- Helping you and your patients close identified and confirmed gaps in care by providing information such as using generic prescription drugs instead of brand name drugs and using reminder systems for taking prescription medications and receiving preventive services. They can also provide access to services like smoking cessation, dietary management, care for depression, and stress management.
- Assisting with access to necessary services including specialty, skilled nursing, physical therapy, durable medical equipment, chronic condition management programs, and mail order pharmacy (as well as providing information on the approved drug list).

For more information, or to refer a patient to a case management program, please call 1.844.890.7616.

**Complex Case Management**

Complex case management is for members needing short-term or long-term extra support, and catastrophic cases. Our case management programs offer a highly focused, integrated approach that promotes access to evidence-based and cost-effective healthcare. The complex case management program is designed to enhance the quality of care and quality of life for members with severe and complex conditions.

Case managers are experienced nurses who work with you, your patients and their families to help coordinate care and benefits, explore care alternatives, monitor progress, coordinate discharge planning and follow-up, and help ensure that benefits are used effectively. The process typically includes the main components of case identification, case assessment, service plan implementation, service plan evaluation, and case closure.

Case management teams use targeted evidence-based tools to identify and monitor program members, enhance care coordination, address potential gaps in care, and help members get the most from their health care plan.

**Specialty Case Management**

In addition to our complex case management programs, we offer several focused specialty case management programs that can help positively affect an individual’s health, while reducing medical costs.

Dedicated nurse case managers with specific expertise and training work collaboratively with you and specialty physician leads to help support patients with high-risk maternity conditions,
infants requiring neonatal intensive care unit (NICU) care, patients with cancer, and patients needing a transplant.

These programs are a vital enhancement to our standard case management programs and are designed to help members with significant, complex conditions become more active, informed members in their own care.

These case management programs are available at no additional charge to your patients or to their employers. For more information, or to refer a patient, please call:

- Complex case Management – 1.844.890.7616
- High risk maternity - 1.844.890.7616
- Neonatal intensive care (NICU) or oncology - 1.800.882.4462
- Transplant - 1.800.668.9682

**Mental Health and Substance Abuse Program**

Mental health and substance abuse services are provided through Cigna Behavioral Health, Inc.

**Vision Care**

Some members have direct access to routine vision care with participating vision health care professionals. You can verify coverage for these individuals online at CignaforHCP.com > Patients > Search Patients. You may also verify coverage through your EDI vendor, or by contacting Customer Service at the number on the back of the patient’s ID card.

**Chiropractic Care**

Some members have direct access to routine chiropractic care with participating chiropractors. You can verify coverage for these individuals online at CignaforHCP.com > Patients > Search Patients. You may also verify coverage through your EDI vendor, or by contacting Customer Service at the number on the back of the patient’s ID card.
Claims and Compensation

Timely and accurate reimbursement is important to you and us. The customer service telephone number and claim center mailing address are displayed on your patient’s ID card. Check the ID card at each visit for the most current information.

<table>
<thead>
<tr>
<th>Claims Payor</th>
<th>Claims Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seton Insurance</td>
<td>P.O. Box 1700</td>
<td>Telephone</td>
</tr>
<tr>
<td></td>
<td>Piscataway, NJ 08855-1700</td>
<td>1.844.883.2422</td>
</tr>
<tr>
<td>LifeSource</td>
<td>See address on referral letter</td>
<td>See telephone and fax numbers in referral letter</td>
</tr>
<tr>
<td></td>
<td>received by provider for one of four offices that processes claims</td>
<td></td>
</tr>
<tr>
<td>Vision Service Plan</td>
<td>P.O. Box 997100</td>
<td>Telephone</td>
</tr>
<tr>
<td>(for routine vision care services only)</td>
<td>Sacramento, CA 95899</td>
<td>1.800.615.1883</td>
</tr>
</tbody>
</table>

Claim Submission

You can help improve claim processing accuracy and timelines by following Seton guidelines. Be consistent with your demographic information when identifying yourself in claim submissions. If you need to change the way you submit claims, refer to the demographics section of this manual. Using abbreviations or variations of names, or doing business as (DBA) names with combinations of your licensure numbers, national provider identifiers (NPIs), and tax identification numbers not listed in the your agreement can delay or result in incorrect claim payments. Notify Seton in advance of changes to your information.

We strongly encourage you to submit your claims electronically.

Electronic Claim Submission

Submitting claims electronically can help you save time, money, and improve claim processing accuracy. Using one of Seton’s electronic data interchange (EDI) options allows you to send, view, and track claims with Seton online—no faxing, printing, or mailing is necessary.

Submitting Claims Electronically to Seton Can Help You:

- Send primary and secondary [coordination of benefits (COB)] claims quickly, reduce paperwork, and eliminate printing and mailing expenses
- Decrease the chance of transcription errors or missing data
- Track claims received electronically
- Eliminate the need to submit claims to multiple locations
- Save time on resubmissions
- Receive confirmation that Seton accepted your claim, or a claim rejection notification.

You can connect directly to Seton and submit your electronic claims using an EDI vendor.

Seton Payor ID for Submitting Electronic Claims:

<table>
<thead>
<tr>
<th>Payor ID</th>
<th>22312*</th>
</tr>
</thead>
</table>

* Both primary and secondary (COB) claims can be submitted electronically to Seton.
Paper Claim Submission

We strongly encourage you to submit claims electronically using ChangeHealthcare.com (formally Emdeon). However, if you need to file a paper claim, use one of these claim forms:

<table>
<thead>
<tr>
<th>UB04 form for hospital charges</th>
<th>CMS-1500 form for all other charges</th>
</tr>
</thead>
</table>

In instances where you must submit a paper claim, follow these guidelines when completing and submitting paper claims:

- If using a super bill or form other than a UB04 or CMS-1500, the form must have the same information fields listed in the “Definition of a Complete Claim” section below.
- Include your national provider identifier (NPI) and/or Federal Tax ID number (TIN) on the claim.
- Make sure all appropriate claim form fields are completed; use black ink when handwriting information.
- Refer to the patient’s ID card for the correct claim submission address.
- Include the patient’s ID number on all claim attachments and correspondence.
- If submitting a replacement or corrected claim, clearly identify it on the claim.

Definition of a Complete Claim

Seton defines a complete claim as a claim that can be processed by Seton or its designee without additional information from the health care professional or a third party.

<table>
<thead>
<tr>
<th>The claim at a Minimum Must Include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name and address</td>
</tr>
<tr>
<td>Patient date of birth and gender</td>
</tr>
<tr>
<td>Subscriber name and address</td>
</tr>
<tr>
<td>Subscriber group number</td>
</tr>
<tr>
<td>Other insurance information</td>
</tr>
<tr>
<td>Referral/approval number</td>
</tr>
<tr>
<td>Admitting/attending physician</td>
</tr>
<tr>
<td>Diagnosis codes (ICD, DRG)</td>
</tr>
<tr>
<td>First date of same or similar illness</td>
</tr>
<tr>
<td>Health care professional name, address and telephone number</td>
</tr>
<tr>
<td>Description of procedure(s)</td>
</tr>
<tr>
<td>Seton Provider ID Number (all digits and suffix)</td>
</tr>
</tbody>
</table>

**Note:** Any state law, HIPAA transaction and code set requirements, or plan-specific language inconsistent with the Seton Standard Administrative Guidelines and Program Requirements will supersede these guidelines in the event of a conflict.
Texas Department of Insurance Definition of Clean Claim

For claims of fully insured members, the Texas Department of Insurance definition of Claim and other claims processing requirements of SB 418 will supersede Seton Insurance standard administrative guidelines. The Texas Department of Insurance definition of a Clean Claim is shown below.

Required Elements of a Clean Claim

For claims filed, or refiled, on or after April 1, 2014:

CMS 1500 – Physicians and Non-Institutional Providers

<table>
<thead>
<tr>
<th>Field #</th>
<th>Data Element</th>
<th>SB 418 Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Subscriber’s or patient’s plan ID number</td>
<td>Required</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s name</td>
<td>Required</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s date of birth and gender</td>
<td>Required</td>
</tr>
<tr>
<td>4</td>
<td>Subscriber’s name</td>
<td>Required (If shown on ID card)</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s address (street or P.O. Box, City, Zip)</td>
<td>Required</td>
</tr>
<tr>
<td>6</td>
<td>Patient’s relationship to subscriber</td>
<td>Required</td>
</tr>
<tr>
<td>7</td>
<td>Subscriber’s address</td>
<td>Required – May enter “same” if address same as patient’s shown in Field 5.</td>
</tr>
<tr>
<td>9</td>
<td>Other insured’s or enrollee’s name</td>
<td>Required – if Field 11d is answered “yes”*.</td>
</tr>
<tr>
<td>9a</td>
<td>Other insured’s or enrollee’s policy/group number</td>
<td>Required – if Field 11d is answered “yes”*.</td>
</tr>
<tr>
<td>9d</td>
<td>Other insured’s or enrollee’s HMO or insurer name</td>
<td>Required – if Field 11d is answered “yes”*.</td>
</tr>
<tr>
<td>10</td>
<td>Whether patient’s condition is related to employment, auto accident, or other accident</td>
<td>Required – but facility-based radiologists, pathologists or anesthesiologists shall enter “N” if answer is “No” or the information is unknown.</td>
</tr>
<tr>
<td>11</td>
<td>Subscriber’s policy number</td>
<td>Required</td>
</tr>
<tr>
<td>11c</td>
<td>HMO or preferred provider carrier name</td>
<td>Required</td>
</tr>
<tr>
<td>11d</td>
<td>Disclosure of any other health benefit plans</td>
<td>Required If answer is “no” provider must have on file patient’s statement signed within last 12 months that there is no other coverage.*</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s or authorized person’s signature or a notation that the signature is on file with the physician or provider</td>
<td>Required</td>
</tr>
<tr>
<td>Field #</td>
<td>Data Element</td>
<td>SB 418 Regulations</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>13</td>
<td>Subscriber’s or authorized person’s signature or notation that the signature is on file with the physician or provider</td>
<td>Required</td>
</tr>
<tr>
<td>14</td>
<td>Date of injury if due to an accident</td>
<td>Required – for primary care and specialty physicians and hospitals. If no referral, enter “self-referral or “none”.</td>
</tr>
<tr>
<td>17</td>
<td>Name of referring physician or other source</td>
<td>Required – for primary care and specialty physicians and hospitals. If no referral, enter “self-referral or “none”.</td>
</tr>
<tr>
<td>17a</td>
<td>ID number of referring physician</td>
<td>Required – for primary care and specialty physicians and hospitals if the referring provider is eligible for a NPI. If no referral, enter “self-referral or “none”.</td>
</tr>
<tr>
<td>17b</td>
<td>NPI number of referring physician</td>
<td>Note: Any provider of medical or other health services, and any other person or organization that furnishes, bills, or is paid for healthcare in the normal course of business – is eligible to receive a provider ID or NPI.</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis codes or nature of illness or injury</td>
<td>For ICD-10 use “0” between the vertical dotted lines in the upper right hand portion of the field. Must enter at least 1 diagnosis code and may enter up to 12 diagnosis codes.</td>
</tr>
<tr>
<td>22</td>
<td>Duplicate or corrected claim</td>
<td>“D” is required for duplicate claim; “C” is required for corrected claim.</td>
</tr>
<tr>
<td>23</td>
<td>Prior authorization number</td>
<td>Required – if services have been verified per §19.1724 of this title (Verification) Otherwise, a prior authorization number is required when prior authorization is required.</td>
</tr>
<tr>
<td>24A</td>
<td>Date(s) of Service</td>
<td>Required</td>
</tr>
<tr>
<td>24B</td>
<td>Place of service codes</td>
<td>Required</td>
</tr>
<tr>
<td>Field #</td>
<td>Data Element</td>
<td>SB 418 Regulations</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>24D</td>
<td>Procedure/Modifier code</td>
<td>Required - if unlisted or not classified code or National Drug Code (NDC) is used, must enter narrative description in the shaded area above the corresponding completed service line.</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis code by specific service</td>
<td>Required – with first code linked to the applicable diagnosis code for that service in field 21.</td>
</tr>
<tr>
<td>24F</td>
<td>Charge for each listed service</td>
<td>Required</td>
</tr>
<tr>
<td>24G</td>
<td>Number of days or units</td>
<td>Required – if the rendering provider is not the billing provider, if the rendering physician is eligible for a NPI.</td>
</tr>
<tr>
<td>24J</td>
<td>NPI number of rendering physician</td>
<td>Note: Any provider of medical or other health services, and any other person or organization that furnishes, bills, or is paid for healthcare in the normal course of business – is eligible to receive a provider ID or NPI.</td>
</tr>
<tr>
<td>25</td>
<td>Physician’s or provider’s federal tax ID number</td>
<td>Required</td>
</tr>
<tr>
<td>27</td>
<td>Whether assignment was accepted</td>
<td>Required – when assignment under Medicare has been accepted.</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td>Required</td>
</tr>
<tr>
<td>29</td>
<td>Amount paid</td>
<td>Required – if amount has been paid by or on behalf of the patient or subscriber or by a primary plan.</td>
</tr>
<tr>
<td>31</td>
<td>Signature of physician or provider or notation that signature is on file with the carrier</td>
<td>Required</td>
</tr>
<tr>
<td>32</td>
<td>Name and address of facility where services were rendered (if other than home or office)</td>
<td>Required</td>
</tr>
<tr>
<td>32A</td>
<td>NPI number of facility where services were rendered if not a home</td>
<td>Required – if facility is eligible for an NPI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Any provider of medical or other health services, and any other person or organization that furnishes, bills, or is paid for healthcare in the normal course of business – is eligible to receive a provider ID or NPI.</td>
</tr>
<tr>
<td>Field #</td>
<td>Data Element</td>
<td>SB 418 Regulations</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>33</td>
<td>Physician or provider’s billing name, address and telephone number</td>
<td>Required – in addition to telephone number. Provider number is required if carrier required provider numbers and gave notice of the requirement to physician/provider prior to June 17, 2003. Note: This is not a clean claim element for Seton.</td>
</tr>
<tr>
<td>33A</td>
<td>NPI of billing provider</td>
<td>Required – if billing provider is eligible for NPI. Note: Any provider of medical or other health services, and any other person or organization that furnishes, bills, or is paid for healthcare in the normal course of business – is eligible to receive a provider ID or NPI.</td>
</tr>
<tr>
<td>33B</td>
<td>Provider ID</td>
<td>Required – if the HMO or preferred provider carrier required provider numbers and gave notice requires to physicians and providers prior to June 17, 2003. Note: This is not a clean claim element for Seton.</td>
</tr>
</tbody>
</table>

If answer in field 11d is “Yes”, then data elements in fields 9, 9a and 9d must be completed. If answer is “No”, then fields 9, 9a and 9d are not essential data elements if the physician or provider has a statement on file signed by the patient/insured within the last 12 months that there is no other coverage. Such statement may be in the form of initial or annual office visits questionnaires, patient sign-in sheets, a routine record update, etc.

**UB04 – Institutional Providers**

<table>
<thead>
<tr>
<th>Field #</th>
<th>Data Element</th>
<th>R = Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider’s name, address and telephone number</td>
<td>Required</td>
</tr>
<tr>
<td>3a</td>
<td>Patient control number</td>
<td>Required</td>
</tr>
<tr>
<td>4</td>
<td>Type of bill code</td>
<td>Required - shall include a “7” in the 4th position if claim is a duplicate.</td>
</tr>
<tr>
<td>5</td>
<td>Provider’s federal tax ID number</td>
<td>Required</td>
</tr>
<tr>
<td>Field #</td>
<td>Data Element</td>
<td>R = Required</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6</td>
<td>Statement period (beginning and ending date of claim period)</td>
<td>Required</td>
</tr>
<tr>
<td>8a</td>
<td>Patient’s name</td>
<td>Required</td>
</tr>
<tr>
<td>9a – 9e</td>
<td>Patient’s address</td>
<td>Required</td>
</tr>
<tr>
<td>10</td>
<td>Patient’s date of birth</td>
<td>Required</td>
</tr>
<tr>
<td>11</td>
<td>Patient’s gender</td>
<td>Required</td>
</tr>
<tr>
<td>12</td>
<td>Date of admission</td>
<td>Required – for inpatient admissions, observation stays, and emergency room care.</td>
</tr>
<tr>
<td>13</td>
<td>Admission hour</td>
<td>Required – for inpatient admissions, observation stays, and emergency room care.</td>
</tr>
<tr>
<td>14</td>
<td>Type of admission (e.g. emergency, urgent, elective, newborn)</td>
<td>Required – for inpatient admissions</td>
</tr>
<tr>
<td>15</td>
<td>Point of origin for admission or visit code</td>
<td>Required</td>
</tr>
<tr>
<td>16</td>
<td>Discharge hour</td>
<td>Required – for admissions, outpatient surgeries or observation stays.</td>
</tr>
<tr>
<td>17</td>
<td>Patient status-at-discharge code</td>
<td>Required – for admissions, observation stays, and emergency room care.</td>
</tr>
<tr>
<td>18-28</td>
<td>Condition codes</td>
<td>Required – if the CMS UB-04 manual contains a condition code appropriate to patient’s condition.</td>
</tr>
<tr>
<td>31-34</td>
<td>Occurrence codes and dates</td>
<td>Required – if the CMS UB-04 manual contains an occurrence code appropriate to patient’s condition.</td>
</tr>
<tr>
<td>35-36</td>
<td>Occurrence span code, from and through dates</td>
<td>Required – if the CMS UB-04 manual contains an occurrence span code appropriate to patient’s condition.</td>
</tr>
<tr>
<td>39-41</td>
<td>Value code and amounts</td>
<td>Required – for inpatient admissions. If no value codes are applicable to admission, provider can enter value code 01.</td>
</tr>
<tr>
<td>42</td>
<td>Revenue code</td>
<td>Required</td>
</tr>
<tr>
<td>43</td>
<td>Revenue description</td>
<td>Required</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS or Rates</td>
<td>Required – if Medicare is a primary or secondary payor.</td>
</tr>
<tr>
<td>Field #</td>
<td>Data Element</td>
<td>R = Required</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>45</td>
<td>Service date</td>
<td>Required – if claim is for outpatient services</td>
</tr>
<tr>
<td>45-line 23</td>
<td>Date bill submitted</td>
<td>Required</td>
</tr>
<tr>
<td>46</td>
<td>Units of Service</td>
<td>Required</td>
</tr>
<tr>
<td>47</td>
<td>Total Charge</td>
<td>Required</td>
</tr>
<tr>
<td>50</td>
<td>HMO or preferred provider carrier name</td>
<td>Required</td>
</tr>
<tr>
<td>54</td>
<td>Prior payments - payor and patient</td>
<td>Required – if payments have been made to provider by or on behalf of patient or subscriber or by a primary plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Required – if the billing provider is eligible for a NPI number.</td>
</tr>
<tr>
<td>56</td>
<td>NPI number of the billing provider</td>
<td>Note: Any provider of medical or other health services, and any other person or organization that furnishes, bills, or is paid for healthcare in the normal course of business – is eligible to receive a provider ID or NPI.</td>
</tr>
<tr>
<td>57</td>
<td>Other provider number</td>
<td>Required – if the preferred provider carrier, prior to June 17, 2003, required provider numbers and gave notice of that requirement to physicians and providers</td>
</tr>
<tr>
<td>58</td>
<td>Subscriber’s name</td>
<td>Required – if shown on patient’s ID card.</td>
</tr>
<tr>
<td>59</td>
<td>Patient’s relationship to subscriber</td>
<td>Required</td>
</tr>
<tr>
<td>60</td>
<td>Patient’s/subscriber’s certificate number, health claim number, ID number</td>
<td>Required – If shown on patient’s ID card.</td>
</tr>
<tr>
<td>62</td>
<td>Insurance group number</td>
<td>Required – If a group number is shown on the patient’s ID card.</td>
</tr>
<tr>
<td>63</td>
<td>Verification codes</td>
<td>Required- if services have been verified per §19.1724 (Verification). Otherwise, treatment authorization codes are required when authorization is required</td>
</tr>
<tr>
<td>Field #</td>
<td>Data Element</td>
<td>R = Required</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>67</td>
<td>Principal diagnosis code</td>
<td>Required</td>
</tr>
<tr>
<td>67a – 67q</td>
<td>Diagnoses codes other than principal diagnosis code</td>
<td>Required – if there are diagnoses other than the principal diagnosis</td>
</tr>
<tr>
<td>69</td>
<td>Admitting diagnosis code</td>
<td>Required – if patient has undergone an inpatient or outpatient surgical procedure</td>
</tr>
<tr>
<td>74</td>
<td>Principal procedure code</td>
<td>Required – as an extension of Field 74 if additional surgical procedures were performed</td>
</tr>
<tr>
<td>74a – 74e</td>
<td>Other procedure code</td>
<td>Required – on or after 5/23/08, if attending physician is eligible for an NPI number.</td>
</tr>
<tr>
<td>76</td>
<td>Attending physician NPI number</td>
<td>Note: Any provider of medical or other health services, and any other person or organization that furnishes, bills, or is paid for healthcare in the normal course of business – is eligible to receive a provider ID or NPI.</td>
</tr>
<tr>
<td>76 – qualifier portion</td>
<td>Attending physician ID</td>
<td>Required</td>
</tr>
</tbody>
</table>

**Data Element Requirements for Electronic Clean Claims**

**SB 418 Regulations Only for claims filed, or refiled, on and after April 1, 2014**

An electronic claim is considered clean if it is submitted following the applicable format that complies with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements.

**Present on Admission (POA) Indicator**

Seton requires the POA indicator to be present for all diagnosis codes submitted on the inpatient claim form. Seton reserves the right to return any inpatient claim without a POA indicator. For additional information, please refer to reimbursement policies at [https://navinet.navimedix.com](https://navinet.navimedix.com).

**Supplemental Claim Information**

Sometimes it is necessary to include additional information to support a claim or make a benefit determination. Supplemental documentation should be included or sent as soon as
possible after requested to avoid delays in claim processing.

Requests for supplemental claim information are sent to the address we have on file for you in our demographic databases. Those addresses could potentially be locked boxes for claim payment. Please make sure we have the most current and correct mailing address for you in our database so you receive supplemental claim information requests and other correspondence from us in a timely manner.

In the table below is a sample of claim categories that require supplemental information. A complete, up-to-date listing is available at [www.setoninsurance.com](http://www.setoninsurance.com).

Requirements. (The requirement to provide supplemental claim information is subject to applicable law and, in the event of a conflict, applicable law will control.)

<table>
<thead>
<tr>
<th>Claim Category</th>
<th>Supplemental Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air ambulance</td>
<td>Narrative/transport notes</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Time must be specified</td>
</tr>
<tr>
<td>Billing Appropriateness</td>
<td>Itemized bill/clinical records or notes</td>
</tr>
<tr>
<td>Coordination of Benefits (COB)</td>
<td>Seton payer ID is able to receive COB claims electronically. Please contact your vendor for information on how to submit COB claims electronically.</td>
</tr>
<tr>
<td></td>
<td>For paper claims, provide a copy of the primary carrier’s explanation of payment (EOP) when Seton is secondary.</td>
</tr>
<tr>
<td>Cosmetic or Potentially Cosmetic Procedures</td>
<td>Operative report</td>
</tr>
<tr>
<td></td>
<td>Office notes and treatment plan</td>
</tr>
<tr>
<td></td>
<td>History and physical</td>
</tr>
<tr>
<td></td>
<td>Photos (if available)</td>
</tr>
<tr>
<td></td>
<td>Height/weight</td>
</tr>
<tr>
<td></td>
<td>Operative report and treatment results (if already performed)</td>
</tr>
<tr>
<td></td>
<td>(For Blepharoplasty – visual field testing results)</td>
</tr>
<tr>
<td>DRG Clinical Review</td>
<td>Clinical records or notes</td>
</tr>
<tr>
<td></td>
<td>Healthcare Common Procedure Coding System (HCPCS) or National Drug Codes (NDC)*.</td>
</tr>
<tr>
<td>Drugs--Injectable</td>
<td>Seton requires the National Drug Code (NDC) number be included in addition to the Healthcare Common Procedure Coding System (HCPCS) code on some claims, when the patient’s health plan requires precertification. The list of specialty medications that are included in this requirement, details on which claims require the NDC number, information about where to include the NDC on the claim and additional information can be found on <a href="http://https://navinet.navimedix.com">https://navinet.navimedix.com</a>.</td>
</tr>
</tbody>
</table>
### Claims and Compensation

<table>
<thead>
<tr>
<th>Claim Category</th>
<th>Supplemental Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental, Investigational or Unproven Procedures</td>
<td>Operative or physician notes and other relevant clinical information.</td>
</tr>
<tr>
<td>High Dollar Claims</td>
<td>Itemized bill</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>- Office notes and treatment plan</td>
</tr>
<tr>
<td></td>
<td>- All visit notes, complete history and physical</td>
</tr>
<tr>
<td></td>
<td>- Infusion drug report, if applicable</td>
</tr>
<tr>
<td>Modifiers:</td>
<td>Operative, office or physician notes or other clinical information (A select few NCCI</td>
</tr>
<tr>
<td></td>
<td>modifier 25 and 59 code pairs require documentation with the initial professional claim</td>
</tr>
<tr>
<td></td>
<td>(CMS-1500) submission. Claims should continue to be submitted electronically to Cigna,</td>
</tr>
<tr>
<td></td>
<td>even if supporting documentation is required. Indicate in the PWK (Claim Supplemental</td>
</tr>
<tr>
<td></td>
<td>Information) segment of Loop 2300 of the electronic claim that the documentation will</td>
</tr>
<tr>
<td></td>
<td>be sent through another channel. Refer to the Modifier 25 and 59 Policies and code lists</td>
</tr>
<tr>
<td></td>
<td>available on the <a href="https://navinet.navimedix.com">https://navinet.navimedix.com</a> secure</td>
</tr>
<tr>
<td></td>
<td>portal.</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>- Complete history and physical</td>
</tr>
<tr>
<td></td>
<td>- Proposed treatment plan, including any surgical procedures</td>
</tr>
<tr>
<td></td>
<td>- Measures tried previously and patient’s response</td>
</tr>
<tr>
<td>Pre-determinations</td>
<td>- Office notes and treatment plan</td>
</tr>
<tr>
<td></td>
<td>- Complete history and physical</td>
</tr>
<tr>
<td></td>
<td>- Photographs, if applicable</td>
</tr>
<tr>
<td></td>
<td>- Pertinent Diagnostic Study Results</td>
</tr>
<tr>
<td>Provider Stop Loss (Facility only)</td>
<td>Itemized by date of service and revenue code may be needed depending on the type of stop</td>
</tr>
<tr>
<td></td>
<td>loss prevention.</td>
</tr>
<tr>
<td>Unexpected Place of Service (example: office services performed in an ASC,</td>
<td>Operative or provider notes or other clinical information.</td>
</tr>
<tr>
<td>etc.)</td>
<td>- A clear description of the service, device or procedure provided, if the unlisted</td>
</tr>
<tr>
<td></td>
<td>code is submitted for a drug, provide the name, dosage, NDC number and medical necessity</td>
</tr>
<tr>
<td></td>
<td>for the drug. If the unlisted code is for a surgical service, provide the operative</td>
</tr>
<tr>
<td></td>
<td>report</td>
</tr>
<tr>
<td></td>
<td>- Reference to whether the service, device or procedure was provided separately from</td>
</tr>
<tr>
<td></td>
<td>any other service, device or procedure rendered</td>
</tr>
<tr>
<td></td>
<td>- Information to establish medical necessity for the service, device or procedure</td>
</tr>
<tr>
<td></td>
<td>- Radiology – detailed description of the approved radiology procedure</td>
</tr>
<tr>
<td></td>
<td>- Laboratory/Pathology – Laboratory or Pathology report pointing out the specific test</td>
</tr>
<tr>
<td></td>
<td>used</td>
</tr>
</tbody>
</table>
Claim Filing Deadline

Claims should be filed as soon as possible to promote prompt payment. Seton will only consider claims submitted within 95 days of the date of service, or as otherwise defined in your provider agreement, or later in the case of certain exceptions as 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.

The following are current exceptions to the 95-day time limit:

- Applicable state law provides for a longer timely filing limit in which case that time limit will apply
- Coordination of benefits (95-day filing limit is applied based on the primary carrier’s processing date as stated on an explanation of benefit or payment)
- Resubmission of a claim originally filed in a timely manner, returned with new or additional information as requested by Seton (95-day filing limit is reset to the date of the Seton request for more information)
- Services provided to members through arrangements with third-party vendors (filing limit is applied based on third-party requirements, which may be more or less than 95 days)
- Extenuating circumstances (e.g., catastrophic events)

Claim Inquiry and Follow-Up

Health care professionals can inquire about claim status using your EDI vendor; our website, https://navinet.navimedix.com, interactive voice response (IVR) systems; or by calling the Seton customer service number on the patient’s ID card or on the explanation of payment.

When contacting Seton, have the following information available:

<table>
<thead>
<tr>
<th>Health care professional name</th>
<th>National Provider ID number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taxpayer Identification Number (TIN)</td>
<td>Patient name</td>
</tr>
<tr>
<td>Patient ID</td>
<td>Subscriber name</td>
</tr>
<tr>
<td>Date of service</td>
<td>Description of service</td>
</tr>
<tr>
<td>Amount of claim</td>
<td>Date claim was submitted</td>
</tr>
</tbody>
</table>

Our website is available to health care professionals for verifying claim status by logging in to the Seton website, https://navinet.navimedix.com.

You can connect directly to Seton and submit your electronic claims through an EDI vendor. To learn more about connecting electronically with Seton visit ChangeHealthcare.com or call Seton Customer Service at 1.844.883.2422.
The claim inquiry and follow-up options listed above allow health care professionals to access details of processed claim information 24 hours a day, seven days a week. When inquiring on the status of a claim on the website you will receive:
- Seton claim number
- Total charge and paid amounts
- Claim processed date
- Payment date, method (check or electronic funds transfer) and check number
- Claim status history available for two years

By calling the number on the member’s ID card, you can either access the automated IVR system for claim status 24 hours a day, seven days a week, or speak to a Customer Service Representative during normal business hours.

**Claim Payment Policies and Procedures**

Claims from participating health care professionals are subject to our claim payment policies and procedures. These policies are the guidelines adopted by us for calculating payment of claims and include our standard claim code auditing methodology, review of charges to service provided and procedures for claims adjudication. This manual contains information about some of our payment policies. Please review the information online or call the number listed on the member’s ID card for additional questions or information.

**Standard Claim Coding/Bundling Methodology**

If you have questions concerning our standard claim coding, bundling methodology, payment policies, or about how specific types of billing codes will be processed, you can visit the secure Cigna for Health Care Professionals website at [CignaforHCP.com](http://CignaforHCP.com) > Resources > Policies and Procedures > Claim Editing Policies and Procedures).

**Assistant-at-Surgery Modifiers**

This information pertains to physicians and other health care professionals only.

Assistant-at-surgery (MD or non-MD) services are reported by appending one of the modifiers below to the appropriate CPT/HCPCS procedure code. Allowed amounts are based upon the member’s benefit plan and your contractual agreement with us.

Please note that not all Seton insured or administered benefit plans cover non-physician assistants at surgery. When required, another participating physician should be used as an assistant-at-surgery to help the patient maximize his or her benefits.

Assistant Surgeons (modifiers 80, 81, 82) and Assistants-at-Surgery (modifier AS) are processed per CMS National Physician Fee Schedule designations to Allow or Not Allow. CMS Assistant Surgeon/Assistant-at-Surgery designations of “2” are allowed without documentation.

Seton requires supporting documentation to be submitted with the initial claim in order to be considered for payment if CMS assigns the CPT or HCPCS code a ‘0’ designation (may be payable with documentation) for Assistant Surgeons or Assistants-at-Surgery.

For additional information, please refer to the “Modifiers 62, 66, 80, 81, 82 and AS” Reimbursement Policy and Assistant Surgeon Code Listing on the secure Cigna for Health Care Professionals website [CignaforHCP.com](http://CignaforHCP.com) > Policies and Procedures > Modifiers and Reimbursement Policies).
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Definition</th>
<th>Reimbursement Policy*</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Assistant Surgeon</td>
<td>Physician Assistant-at-Surgery: 16% of the allowed amount based on contracted rate or usual and customary (U&amp;C). An Assistant Surgeon must actively assist the Primary Surgeon through an entire operative procedure.</td>
</tr>
<tr>
<td>81</td>
<td>Minimum Assistant Surgeon</td>
<td>Physician Assistant-at-Surgery: 13% of the allowed amount based on the contracted rate or usual and customary U&amp;C. An Assistant Surgeon must actively assist the Primary Surgeon through an entire operative procedure.</td>
</tr>
<tr>
<td>82</td>
<td>Assistant Surgeon (when qualified resident surgeon not available)</td>
<td>Physician Assistant-at-Surgery: 16% of the allowed amount based on contracted rate or usual and customary U&amp;C. An Assistant Surgeon must actively assist the Primary Surgeon through an entire operative procedure.</td>
</tr>
<tr>
<td>AS</td>
<td>Physician Assistant, Nurse Practitioner, Registered Nurse, First Assistant, Advanced Practice Registered Nurse/Advanced Practice Nurse, or Clinical Nurse Specialist services for assistant at surgery</td>
<td>Non-Physician Assistant-at-Surgery: 13.6% of the allowed amount based on contracted rate or usual and customary U&amp;C. The Assistant-at-Surgery must actively assist the Primary Surgeon through an entire operative procedure. Note: not all benefit plans cover non-physician assistants at surgery.</td>
</tr>
</tbody>
</table>

*Note: All covered services are subject to our multiple procedure policy and the provider agreement, as well as our other standard claim coding methodologies (e.g., ClaimsXten®, Modifier Policy).

**Multiple Surgery Policy**

Multiple surgeries or medical procedures (modifier 51) are separate procedures that are performed by a single physician, on the same patient, on the same day (or at the same session) for which separate payment may be allowed. This policy does not apply to procedures that are deemed modifier 51 exempt or to add-on codes as defined by the American Medical Association. If appended correctly, reimbursement for modifier 51 is generally 100 percent of the allowed amount for the primary procedure and 50 percent of the allowed amount for secondary procedure.

Bilateral surgeries (modifier 50) are bilateral procedures that are performed at the same operative session. If appended correctly, modifier 50 is applicable only to services or procedures that are performed on identical anatomical sites, aspects, or organs. Modifier 50 does not apply to codes that are inherently bilateral by definition; reimbursement is 100 percent of the allowed amount for the first procedure and 50 percent of the allowed amount for the second procedure.
Assistant surgeon, co-surgeon and team surgeon fees are subject to the multiple procedure policy.

Participating providers cannot balance bill members for charges in excess of Seton allowable amounts.

In some cases, an office visit is not separately reimbursable from the surgical code so the office visit copayment does not apply.

This policy may not apply to facility charges. The administration of multiple surgical reductions will be determined by the facility contract.

Immunization Policy

This information pertains to physicians and other health care professionals only.

Routine immunizations are covered as medically necessary when both of the following criteria are met:

- They are used in accordance with an FDA-licensed indication
- They are used in accordance with an affirmative recommendation by the CDC’s Advisory Committee on Immunization Practices (ACIP)

Routine disease prevention vaccines are covered when noted in the provisional affirmative recommendations by the Advisory Committee on Immunization Practice (ACIP), until the recommendations are officially published in the Morbidity and Mortality Weekly Report (MMWR).

Global Maternity Reimbursement Policy

We have created a Global Maternity Reimbursement Policy that outlines our standards for reimbursement of global maternity services.

To view the complete policy, as well as our other reimbursement policies, log in to the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Modifiers and Reimbursement Policies), or call 1.800.88Cigna (882.4462). If you are not currently registered for the website, go to CignaforHCP.com and click on “Register Now”.

Please note that this policy has applied to claims processed since August 1, 2010.

Member Liability Collection Guidelines

**Copayments:** Copayment is a fixed dollar amount that a member pays per service. Copayment amounts are printed on the Cigna ID card. Collect the applicable copayment amounts on the ID card at the time of service.

**Coinsurance & Deductibles:** For members with plans that have deductibles or require members to pay a percentage of the covered charges (coinsurance) after satisfying any deductible amount, submit claims to Seton or its designee and receive an explanation of payment (EOP) indicating the members’ responsibility before billing patients. Coinsurance and deductibles should not be collected at the time of service unless you have obtained an estimate.
of the deductible and coinsurance obligations of the plan member, and provided a copy of the estimate to the member at the time of service.

The Seton cost of care estimator can inform you and your patients that participate in Seton medical or behavioral plans of their estimated financial responsibility for services based on their specific Seton insured or administered plan. You can access the tool by logging in to the secure portal at https://navinet.navimedix.com.

**Fee Forgiving/Waiver of Copayment/Coinsurance or Deductible:** Most benefit plans insured or administered by Seton exclude from the member’s coverage those charges for which the member is not obligated to pay. Therefore, if a plan member is not obligated to pay a charge, any claim for reimbursement for any part of that charge under such a contract or benefit plan is generally not covered. It is Seton’s view that “fee- forgiving” on any particular claim, or any portion thereof, could constitute fraud and may subject a provider to civil and criminal liability.

**Denied Payment and Member Non-Liability**

You cannot bill members for covered services or services for which payment was denied due to your failure to comply with your provider agreement or these Program Requirements/Administrative Guidelines, including Seton utilization management requirements and timely filing requirements.

**Coordination of Benefits (COB)**

Seton members may be covered by more than one health benefit plan. In some cases, payment may be the primary responsibility of other payers. Billing multiple health benefit plans to obtain payment is called coordination of benefits (COB). You should assist Seton to maximize recoveries under COB and bill services to the responsible primary plan. After receiving a payment or denial notice from the primary plan, you should submit the COB claim electronically to Seton. However, if you submit COB claims on paper, then a copy of the primary payer explanation of payment is required.

Seton payor ID is able to 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 [Claim Submission](#) section of this manual.

**Seton as Primary Payor**

When the Seton plan is primary payor, payment is made in accordance with your agreement with Seton without regard to the secondary plan. After receiving payment from Seton, submit the COB claim to the secondary plan.

**Seton as Secondary Payor**

When the Seton plan is secondary payor, first submit the claim to the primary plan. After receiving a payment or denial notice from the primary plan, submit the claim to Seton, along with a copy of the primary plan EOP. Paper copies are not required if you submit HIPAA-compliant COB content electronically through an EDI claims submission.

Seton participates in Medicare COBA (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. The Medicare explanation of benefit (EOB) or Electronic Remittance Advice (ERA) will show that
liable for providing health insurance coverage, the birthday rule is followed.

Seton’s payment as secondary payor, 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 Seton provider agreement, and is subject to the terms and conditions of the member’s health benefit plan and applicable state and federal law. Use of applicable COB provisions may result in a payment from Seton that is less than 100 percent of your payment for Covered Services under your Seton provider agreement, when added to the amount payable from other sources.

When Medicare is the primary payer and the Seton administered plan is the secondary payor, applicable Medicare billing rules (including Medicare COB rules) will apply to your reimbursement. The financial responsibility of the Seton administered plan, as a secondary payor under Medicare COB rules is limited to the member’s financial liability (i.e., the applicable Medicare copayment, coinsurance, and/or deductible) after application of the Medicare-approved amount. The Medicare payment plus the member liability (applicable Medicare copayment, coinsurance, and/or deductible) amounts constitute payment in full, and you are prohibited from collecting any monies in excess of this amount.

**Order of Benefit Determination**

Seton follows the National Association of Insurance Commissioners (NAIC) guidelines about the industry standard of order of benefit determination subject to applicable law and the terms of the benefit plan.

**Determining Primacy on a Participant/Spouse**

The plan that covers a person as an employee, subscriber or retiree is always considered the primary payer over a plan that covers the person as a spouse or dependent. If a Seton subscriber has two employers and has group health insurance coverage through both, the plan for the subscriber who has worked longer for the company is considered primary.

If a person has coverage under a state or federal continuation plan and is covered under another group health insurance plan, the plan covering the person as an employee, subscriber or retiree (or as that person’s dependent) is primary and the continuation coverage is secondary.

**Determining Primacy on a Dependent Child**

Dependent children of parents who are married and living together follow the “birthday rule.” The plan of the parent whose birthday falls earlier in the calendar year is primary to the plan of the parent whose birthday falls later in the year. Only the month and day of birth are relevant; birth year is not taken into consideration. If both parents have the same birthday, the parent with the plan that has been in effect longer is primary.

Dependent children of parents who are divorced, separated or not living together follow the “custodial rule.” If a court decree states that one of the parents is responsible for the dependent child’s health care coverage, that parent’s plan is primary, followed by the plan of the other parent. If a court decree awards joint custody without specifying which parent is liable for providing health insurance coverage, the birthday rule is followed.

If there is no court decree allocating responsibility for the dependent’s health coverage, the order of benefit determination under the custodial rule is as follows:
1. The plan of the custodial parent
2. The plan of the custodial parent’s spouse, if applicable
3. The plan of the non-custodial parent
4. The plan of the non-custodial parent’s spouse, if applicable

Determining Primacy with Medicare

For Medicare beneficiaries, the order of benefit determination is determined by federal law or regulation, which may differ from the rules described above. The group health plan that covers Medicare beneficiaries, age 65 or older, through active employment (theirs or that of their spouse) and where the employer has 20 or more employees is the primary payer.

The group health plan is primary for Medicare beneficiaries who have end-stage renal disease (ESRD) during the first 30 months of their Medicare eligibility.

Workers’ Compensation

Health care professionals must submit a potential workers’ compensation claim to the applicable workers’ compensation carrier for review before submitting the claim to us. If the workers’ compensation carrier denies the claim, a copy of the denial must be included with the claim submission to us. If the workers’ compensation denial is not received with the claim, payment for services will be denied unless state law specifically prohibits a denial on these grounds.

Part of the post-review process may include a Seton vendor contacting the patient for information about the case. If it is determined that we have made a medical payment on a valid workers’ compensation case, we will require a full refund. The Seton vendor will provide information about that process. In this case, you should then resubmit the claim to the workers’ compensation carrier responsible for payment.

Subrogation and Reimbursement Requirements

Subrogation may apply if a patient is injured in an accident of any type, and someone else is responsible for the injury. If you treat a patient with a subrogation claim, your contract, as well as these Administrative Guidelines and Program Requirements, will apply to the same extent that they apply to any other member. Appropriate authorizations must be obtained to help ensure payment. Additionally, please note that claims should be submitted to us.

Other Billing Guidelines

This information pertains to hospitals and ancillary facilities only.

Emergency Department

The emergency department copayment provision will not apply when a member is admitted directly from, or within 24-hours of, a related emergency department visit.

Pre-Admission and Pre-Ambulatory Testing

Facility claims for pre-admission or pre-ambulatory testing and procedures completed within three days of an elective admission, ambulatory surgery, or diagnostic procedure should be submitted with the claim for the corresponding admission or procedure. These services will be considered and processed as part of the inpatient claim.
Hospital Interim Billing

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.

Overpayment Recovery

If you receive an overpayment or an otherwise incorrect or inadvertent payment from Seton or its designee, a refund to the payer is required. Send the refund and a copy of the associated explanation of payment to:

Seton Insurance Company  
Attn: Finance  
PO Box 1700  
Piscataway, NJ 08855-1700

Seton contracts with several vendors to administer the recovery of overpayments. You will be advised when an overpayment has been identified and will be expected to promptly refund any overpaid amount. Our standard recovery method is by refund check. Failure to comply with recovery efforts may result in Seton initiating the dispute resolution process set forth in your participating agreement. We reserve the right to reduce future reimbursement amounts to recover previous overpayments subject to all statutory and contractual requirements.

Explanation of Payment

The Seton explanation of payment (EOP) itemizes the services processed or considered for payment. We use a standard format for payment explanations, combining the check and claim detail information. The information necessary to reconcile a patient’s account with the Seton payment is provided in a single document. This consolidated format is called the “Check/EOP.”

You must be a registered user of the ChangeHealthcare website to access this information. Register by going to ChangeHealthcare.com and clicking “Register Now”.

Explanation of Benefits and Explanation of Payment

An explanation of benefits (EOB) or explanation of payment (EOP) accompanies all claims payments. The EOB and EOP itemize payment information such as copayments, deductibles, patient responsibility amounts, contracted discounts, payment amounts and date(s) of service. The payment will be attached at the bottom of the EOB/EOP.

Electronic Funds Transfer and Electronic Remittance Advice

Seton offers electronic funds transfer (EFT) and electronic remittance advice (ERA). By enrolling in EFT and ERA together, you can access your funds and complete your accounts receivable posting faster.

EFT, also known as direct deposit, offers a secure method for funds to be deposited directly into your bank account for claim fee-for-service and capitated payments. Reimbursement payments are available the same day the direct deposit is electronically transferred to your bank account.
What are the benefits of EFT?

- Eliminate paper check mail delivery and handling.
- Access funds on the same day of the deposit.
- Increase efficiency and improve cash flow.
- Easily reconcile payments using a single remittance tracking number.
- View a separate remittance report online for each deposit, which shows the:
  - Deposit transaction
  - Details about the claims processed
  - Payments included in that fund transfer
- To view remittance reports for each deposit on the ChangeHealthcare website:
  - If you are already registered for the website and have access to claims status inquiry, you automatically have access to online remittance reports.
  - Primary Administrators: If you have staffs that need access to online remittance reports, log in to ChangeHealthcare.com.
  - If you are not yet registered for the website, visit ChangeHealthcare.com and click “Register Now”. Once you complete the registration information and it has been validated, you can access your remittance reports online.
- To access your remittance reports, log in to ChangeHealthcare.com.
- The remittance report shows the deposit transaction, details of the claims processed and payments included in that fund transfer.

Two options to enroll in EFT

- Enroll in EFT and manage EFT accounts with multiple payers, including Seton, using the Council for Affordable Quality Health Care (CAQH) website: [https://solutions.CAQH.org](https://solutions.CAQH.org)
- Enroll in EFT directly with Seton by logging in to ChangeHealthcare.

EFT enrollment guidelines

For EFT and ERA enrollment guidelines please contact ChangeHealthcare via their website, [ChangeHealthcare.com](https://www.ChangeHealthcare.com) or by phone at 1.866.506.2830

Posting Payments and Adjustments

In addition to posting applicable payments, you are required to make contractual adjustments to reconcile a patient’s account based upon the Seton contractual or negotiated rate, and as noted on the EOP. Contractual adjustments are reflected on the EOP, ERA or other Seton remittance or payment statement.

Applicable Rate

This information pertains to hospitals and ancillary facilities only.

The rates detailed in your provider participation agreement extend to services performed on a Seton member, including services covered under the member’s in-network and out-of-network benefits. This is true whether it is the Payer or the member who is financially responsible for payment.
New Rates and Changes to Coverage

This information pertains to hospitals and ancillary facilities only.

If a member with Seton-administered coverage is an inpatient when a new contracted rate becomes effective, or when the member’s benefit plan changes to a different type of plan (e.g., OAP to HMO, HMO to PPO):

- The hospital’s reimbursement for covered services during the inpatient stay will be based upon the rates in effect on the day the patient was admitted to the hospital.
- If a member with Seton-administered coverage is an inpatient when their coverage status changes:
  - The hospital’s reimbursement for covered services will be prorated based on the total number of days of the entire length of stay that the patient had Cigna coverage.

Claim Quality and Medical Cost Programs

We manage claims and perform reviews through various quality and medical cost programs. These programs continue to provide quality results, control medical costs, and improve our members’ experience.

Prepayment Reviews

The Prepayment Review program works in harmony with other Cigna quality initiatives to help achieve accurate claim processing. Through this program, we can proactively identify claims that may require additional attention and, when necessary, correct claims prior to payment.

Clinical Claim Reviews

The Clinical Claim Review program enables us to review claims for accuracy and appropriateness prior to payment. As part of this program, we may check claims against coverage or reimbursement policies and ensure coverage alignment with a patient’s benefit plan. An experienced team of health care professionals, including nurses and physicians, review billing and coding for accuracy.

Postpayment Reviews

The Postpayment Review program enables us to review claims after claims are paid. Nurse and physician reviewers compare a facility’s itemized bill and invoices (e.g., for implantable devices) to the events, services, and items documented in the patient’s medical record. Medical coding is also reviewed to help ensure it meets current nationally recognized standards and accurately represents documented services.

Postpayment Claim Selection & Process

This audit protocol is intended to supplement standard audit provisions contained in Seton Hospital Agreements. If this protocol conflicts with the audit terms in the Seton Hospital Agreement or the terms of state law, the Seton Hospital Agreement terms and/or applicable state law will prevail.

In conducting these audits, Seton will use nationally recognized guidelines and references including CMS and National Correct Coding Initiative guidelines, the most current and
applicable coding standards and references (CPT4, HCPCS, DRG, ICD10), and MCG Guidelines. In addition, claims will be evaluated to help assure that existing Seton policies and applicable benefit and contract provisions were applied correctly.

To the extent permitted by applicable state law, Seton will select claims paid per contractual responsibility from within the previous six (6) months for Seton members. The criteria for selection include:
- Payor responsibility has been satisfied, and
- Claim payment meets or exceeds $50,000 paid

**Note:** Not all claims meeting the above criteria will be audited. Seton will notify the hospital of its intent to audit as outlined below.

**Scope of Audit**

Claim audits will consist of a review of an itemized bill against the medical record. This review will compare billed charges to documented events/services/items in the patient’s medical record. It will also include a review of invoices for implantable devices and of the medical coding to ensure it aligns with current nationally recognized standards. Non-covered items, such as benefit exclusions and items/services not covered per Seton policy, will be identified. Level of care and medical necessity will be evaluated, as well.

**Seton Notification Process**

Seton will notify the hospital of its intent to audit with a written Notification Letter and request for medical records and other necessary documentation. Within 30 days of such request, required documentation for the claims identified in the Notification Letter must be sent to Seton at the following address:

Seton Insurance Company  
Attn: Administrative Appeals  
PO Box 1700  
Piscataway, NJ 08855-1700

**Required Documentation for the Claims Selected**

Seton expects that upon receipt of the Notification Letter the hospital will respond to this request and submit required information within 30 days or schedule a date for the audit if it is to be held on site. If the audit is to occur on site per the terms of the Hospital Agreement or applicable state law, Seton expects the required documentation will be available for review when Seton representatives arrive to conduct the audit.

Seton typically requires that the hospital submit or provide access to the following information for claims selected for audit:
- Complete Medical Record
- Invoices for implantable devices/orthotics/prosthetics
- Itemized bill
- Operating room report
- Release of Information form signed by the patient, as required. (Most standard hospital release forms signed by the patient upon admission authorize release of patient information to Seton for the purposes of claims review.)
Audit Process

Seton expects there will be no audit fees unless specified in the Hospital Agreement. Seton further expects the hospital will recognize Seton contracted vendors and allow the same level of access to information required to audit as Seton employees when those vendors are working under the scope of this program.

Note that this audit program is separate and distinct from other overpayment recovery programs and related vendor activity, as well as regulatory and credentialing programs.

Time limitations will not apply regarding Seton’s right to audit unless otherwise specified in the Hospital Agreement or applicable law.

Medical necessity and Level of Care findings will be reviewed by a Seton Medical Director.

Post-Payment Audit Findings and Exit Discussion

After completion of the audit, a Preliminary Report of Findings will be shared with the hospital listing all audit findings, including overcharges, undercharges, amount billed/unbilled, discrepancies, and disallowed charges. This report will be provided at the exit meeting if the audit occurs on site or within three business days of the audit completion date if performed off site through conference call.

At the exit conference, the Seton audit team will report findings and explain/clarify results to the hospital representative(s). At that time, the hospital representative will have an opportunity to present any differing audit findings they may have. If required, hospital sign off will be obtained.

If Seton identifies a systemic issue that affects a large subset of claims or consistent significant errors, Seton will work with the hospital on a risk mitigation plan to control further billing errors. This plan may include review of ‘at risk’ claims prior to payment until the issue is resolved.

Post-Audit Response Process

Undisputed refunds are to be submitted by the responsible party within 45 days upon receipt of the audit findings.

Seton will respond to disputes submitted within 30 days of receipt of the audit findings. The notice of dispute must include the specific item and amount under dispute, the basis for disagreement, and supporting documentation/evidence.

Seton will respond to disputes within 30 days of receipt of information from the hospital. If the dispute cannot be resolved, it will be escalated to the Lead Contractor and Regional Contracting Lead. If the dispute pertains to a clinical issue, the dispute will be escalated to the Medical Director.

If we are unable to resolve the dispute, the hospital can pursue resolution as outlined in the Hospital Agreement.
Resolving Payment Questions

You can take these steps prior to providing non-emergency treatment or services to a Seton member as well as prior to submitting the claim for reimbursement to help avoid unnecessary claim processing delays or denials and minimize the need to pursue the dispute resolution process.

Prior to providing services:

- Log in to the secure portal at [https://navinet.navimedix.com](https://navinet.navimedix.com)
  - Verify benefits for the member
  - Review Medical Coverage Policies
  - Determine if precertification is required for outpatient services and if it is, obtain precertification through the same website
- Call Seton Customer Service at the toll-free number on the patient’s ID card.

Prior to Filing a Claim for Reimbursement:

- Ensure either your billing staff or vendor includes all critical information needed for Seton to expeditiously process the claim. Items to include are:
  - Patient name, date of birth, address, gender, and age
  - Health benefits identification number on your patient’s ID card
  - Description of the treatment or service (CPT or HCPCS code)
  - Diagnosis code
  - Specific charge for each service
  - Anesthesia time in hours and minutes
  - Medicare or other insurance EOB, if Seton is the secondary carrier
  - Provider or facility name, address, tax identification number, and National Provider Identifier (if applicable)
  - Provider degree or qualification
  - If billing an unlisted procedure code, a description of the service must be included as well as any clinical notes to support the need for the unlisted code. Both items will expedite the processing of the claim.
- Include modifiers on the claim if they are needed to describe the service performed.
- Attach any clinical notes or documentation needed for Seton to perform a comprehensive review of the claim, including:
  - Letter explaining medical necessity
  - Provider orders, office notes, history, and physical notes
  - Treatment plan or progress notes
  - Facility orders, admission, progress, and discharge notes
  - Test results to include interpretation and report
  - Procedure or operative report
  - Photos for any cosmetic-related procedures

If you are unsure what documentation is required, Seton’s Customer Service will be glad to assist you.

When you receive the explanation of payment (EOP) or Electronic Remittance Advice (ERA), review it carefully to understand Seton’s reimbursement decisions. If you do not understand the reasons provided on the EOP or ERA, or the decision is different from what was expected,
please call Seton Customer Service at 1.844.883.2422 for assistance.

If it is determined that Seton made a claim processing error, the Customer Service Associate will send the claim for correction and no additional action is required by you.

If it is determined that there was an omission or incorrect information was submitted on the claim (e.g., missing field or missing modifier), you will be asked to submit a corrected claim to the address on the member’s Seton ID card. Include “Corrected Claim” on the re-submission. The claim will be re-evaluated with this new information.
Dispute Resolution

Health Care Professional Payment Appeals

Seton strives to informally resolve issues raised by providers on initial contact whenever possible. If an issue cannot be resolved informally, we offer an internal appeal process that may vary depending on the type of issue. As noted in the Provider Agreement and its Administrative Guidelines and Program Requirements, arbitration may serve as a final resolution step.

The payment appeal process is different from routine requests for follow-up inquiries on claim processing errors or missing claim information. The processes in this section apply whenever you have a dispute with Seton about a payment, including disputes over the amount that you believe you should have been paid and if you think you were not paid in a timely manner.

Before you start the appeals process described below, please call Customer Service at 1.844.883.2422 to try to resolve the issue first. Many issues can quickly be resolved by providing requested or additional information.

Before calling Seton, please review the claim and your Seton Provider Agreement to confirm there is an issue. If you still have a question regarding Seton’s reimbursement decision, you may call Customer Service at the toll-free number on the member’s ID card. Please have the information submitted with the claim available when you call: member’s name, date of service, the treating health care professional’s name, and the Tax Identification Number.

If Seton states the claim has been processed correctly, but you disagree, your next step is to file an appeal with Seton (or one of our delegates as noted below). Fee schedule or reimbursement terms for multiple patients do not require individual appeals. Please call Customer Service at 1.844.883.2422 if you need assistance.

Our appeal process is initiated through a written request, or oral request. The appeal process may be a single-level or two-level process depending on state law and the product. This 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 the health care professional’s satisfaction, you may request dispute resolution, including arbitration, as the final resolution step.

Disputes between the parties arising with respect to the performance or interpretation of the Seton Provider Agreement will first be resolved in accordance with the applicable internal dispute resolution (appeals) process outlined in the Administrative Guidelines. If the dispute is not resolved through that process, follow the dispute resolution provisions in your Seton Provider Agreement. The standard dispute resolution process provides that either party may request, in writing, that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within 60 days of a party’s written request for negotiation, either party may initiate arbitration by providing written notice to the other party.

Unless applicable state law provides otherwise, you may not institute arbitration until the health care professional has completed the internal appeals process.

Note: If there is a conflict between this manual and your provider agreement or applicable law, the provider agreement or applicable law will govern.
Note: Seton uses eviCore to manage certain services (e.g., high-technology radiology), including appeals. As such, in these cases, the health care professional should appeal directly through those ancillaries.

Appeals

All appeals are to 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 Seton adjusted, the appeal is to be initiated within 180 calendar days from the date of the last payment adjustment. These time periods are subject to any additional time required under applicable Texas law, or the Provider Agreement.

For additional information on how to submit an appeal, review and follow the Claim Adjustment & Appeals Guidelines on the secure portal at https://navinet.navimedix.com.

Appeal Types and Filing Instructions

Contract and Fee Disputes

When submitting appeals related to your contract, include the following information with your Request for Provider Payment Review form or the appeal request letter:

- Previously submitted claim form (paper or electronic)
- EOP for the services being appealed
- Explanation of line items being appealed
- Payment that was expected and how it was determined by you or your office staff
- Related correspondence and any other documents that may support your position in the dispute

Multiple Patients Disputes

Fee schedule adjustments and reimbursement disputes for multiple patients may not require individual appeals. Please call Customer Service at 1.844.883.2422 so we may provide you with further guidance on how to submit these requests.

Claim Bundling Appeals

Before submitting the appeal request for claim bundling decisions (including NCCI related decisions or mutually exclusive and incidental denials), please review the claim bundling and edit information on the secure portal at https://navinet.navimedix.com. This tool provides relevant explanations for the claim decisions. If you disagree with the reimbursement after review of the information, submit case specific clinical documentation to substantiate the reason for overriding the bundling or edit decision.

Failure to Obtain Precertification When Required

If the reason on the EOP or ERA was related to failure to obtain precertification, please provide the following in the appeal request (either the Request for Provider Payment Review form or appeal request letter):

- Clinical documentation
Medical records
- Any other relevant information including documentation of any extenuating circumstances that prevented you from obtaining a precertification

Medical Necessity

For medical necessity denials or inpatient facility denials related to level of care, length of stay or delayed treatment days, include the complete facility record (e.g., provider orders, progress notes, patient’s medical history and physical exam results, consultations, results of diagnostic testing, operative reports, and discharge summary).

Untimely Claim Submissions

For any claim denial decisions related to untimely claim submission (failure to submit a claim within 95 days of the date of service), submit justification and supporting documentation for the delay with your appeal request. Acceptable documentation includes the electronic data interchange (EDI) transmission report or evidence that a claim was submitted due to coordination of benefits with another carrier.

If you are disputing the timeliness of your payment, include documentation showing the date you submitted the claim and any communications with Seton relating to the claim.

For any documentation required under this section, you are responsible for securing the information from any vendors that you might use.

If, after the health care professional follows with this process, Cigna determines that the initial decision was correct and will be upheld, an appeal denial letter will be sent to you explaining the decision and outlining any additional appeal rights. An appeal determination that overturns the initial decision will be communicated through the explanation of payment with the re-processed claim. Seton reserves the right to reverse a denial decision without completing the appeal process at any point in the Appeal process if warranted by the receipt of new information.

Medical Necessity

If your dispute involves an issue regarding the medical necessity of a service or procedure in addition to a pricing concern, a clinician will review the non-pricing part of your appeal. If your dispute contains a benefits issue in addition to a pricing issue, the Plan’s benefits will be reviewed and our response will refer to those benefits.

Most appeals are resolved within 30 calendar days of receipt. If the dispute concerns a fully insured plan member, state law is followed if it is different from our standard policy. Notification of our decision will be sent to the health care professional within 45 days.

Additional Payment Appeal Options

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 provider agreement. If it is not specified in your provider 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 health care professional’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 providers 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.

**Determinations for Hospital and Facility Appeals**

Unless prohibited by state law, if a hospital or facility fails to request an appeal review, or arbitration of the hospital’s or facility’s payment or termination dispute within the applicable time frames, Seton’s last determination regarding the dispute will be binding. The hospital or facility should not bill the Seton plan member for payments that are denied on the basis that hospital or facility failed to submit the request for review or arbitration within the required time frames.

**Appeals of Pre-Service or Post-Service Medical necessity or Benefits Denials**

For medical necessity denials or inpatient facility denials related to Level of Care, Length of Stay or Delayed Treatment Days, include the complete facility record (i.e., provider orders, progress notes, patient’s medical history and physical exam results, consultations, results of diagnostic testing, operative reports, and discharge summary).

If your dispute involves an issue regarding the medical necessity of a service or procedure in addition to a pricing concern, a clinician will review the non-pricing part of your appeal. If your dispute contains a benefits issue in addition to a pricing issue, the Plan’s benefits will be reviewed and our response will refer to those benefits. Most appeals are resolved within 30 calendar days of receipt. If the dispute concerns a fully insured plan member, state law is followed if it is different from our policy. Notification of our decision will be sent to the health
care professional within 45 days, or earlier if required by state law.

**First Level Review**  
To initiate a Level 1 appeal of a pre-service denial of a request for a prior authorization based on benefit design or medical necessity, follow the appeal process instructions included in the utilization review denial letter.

**Second Level Review**  
If you are not satisfied with the resolution of the first-level review, you may appeal that decision and request a second-level review. The second level review process applicable to each appeal will be explained in the first level decision letter. To request a second level review follow the second level appeal instructions included in the first level decision letter. Return the documentation as directed in the first level determination notice.

**Additional Payment Appeal Options**  
After exhausting the internal appeal process, arbitration may serve as a binding, final resolution step as specified in the Provider Agreement and/or Program Requirements/Administrative Guidelines.
Specialty Networks

We have specialty networks that complement our local health care professional networks. Requirements for referral and precertification of coverage under these arrangements may vary from standard requirements and can be verified by calling Customer Service at the telephone number on the patient’s ID card.

The following specialty networks service the Seton community.

Cigna LifeSOURCE Transplant Network®

Cigna LifeSOURCE Transplant Network includes more than 160 Cigna Centers of Excellence (COE) across the country and the nation’s leading medical facilities renowned for their organ and tissue transplantation programs. This exclusive network gives members with Seton-administered coverage access to over 750 transplant programs for organ and tissue transplantation committed to managing complex transplant procedures.

To be included in Cigna’s Transplant Network, programs must meet quality guidelines for experience, graft, and patient survival rates, as well as transplant team training and experience requirements.

Transplant programs are included in the network at one of the following levels of participation:

1. Program of Excellence (POE) - This is the top tier. To be included as a POE, each solid organ transplant program must be ranked in the top 50th percentile in their region based on the Relative Performance Index. All programs must maintain minimum volumes, patient and graft survival outcomes and accreditations to be designated as a POE. Each bone marrow/stem cell transplant must meet or exceed the minimum 100-day outcomes, minimum annual volumes, and accreditations. Additional details may be found in the document LifeSOURCE Guidelines for Participation on Cigna’s website. Please note, not every transplant program at a Cigna LifeSOURCE participating facility may meet the POE minimum guidelines.

2. Supplemental - Programs not meeting the POE designation are eligible for consideration as a 2nd tier, Supplemental participating program. This valuable solution was developed out of client requests for access to certain transplant programs outside of the POE. While not meeting the more stringent POE standards, these programs must have Centers for Medicaid and Medicare (CMS) certification for solid organs, and Foundation for Accreditation of Cellular Therapy (FACT) and National Marrow Donor Program (NMDP) accreditation for bone marrow/stem cell transplants. There are no minimum volumes or outcomes that must be met. Solid organ transplant programs must demonstrate their ability to maintain CMS certification - if the certification is in jeopardy or has been suspended for any reason, the program may lose its Supplemental designation and will no longer be a participating program in the Cigna LifeSOURCE Transplant Network.

All contracted facilities are reviewed annually. As a result, they may move from one level of participation to the other, or may be removed altogether from being a participating program in the LifeSOURCE network. Please review the LifeSOURCE Guidelines for Participation, as well as the Cigna LifeSOURCE Relative Performance Index Methodology paper for additional information on the Cigna website at www.cignalifesource.com.

The Cigna LifeSOURCE team includes experienced, dedicated staff with transplant- specific
knowledge in case management, contracting, benefit design support, quality assurance, claims re-pricing, and clinical support. This includes a full-time dedicated medical director with a background in transplantation. Cigna LifeSOURCE conducts extensive annual reviews to help ensure transplant facilities maintain quality standards.

Members with Seton-administered coverage who are organ or tissue transplant candidates are assigned specially trained nurse transplant case managers who coordinate care services. These nurses typically have a background in critical care or transplantation and receive extensive training as transplant case managers.

For information about the Cigna LifeSOURCE Transplant Network:

- Visit Cigna LifeSOURCE online at [www.CignaLifeSOURCE.com](http://www.CignaLifeSOURCE.com). Here, you can find the list of Programs of Excellence and Supplemental Cigna LifeSOURCE participating facilities and information about quality guidelines by clicking the “Our Network” tab.
- E-mail Cigna LifeSOURCE at LifeSOURCEweb@cigna.com.
- Call the Cigna LifeSOURCE Transplant Case Management Department at 1.800.668.9682.

**Cigna Behavioral Health**

**Cigna Behavioral Health Members Only.**

Cigna Behavioral Health, Inc. (CBH), our mental health and substance abuse company, provides benefits and case management services to most members with medical benefits through Seton. CBH offers a broad range of services that address the behavioral dimensions of health, disability, and workplace productivity.

Cigna’s behavioral health benefits are managed through regional care centers where our staff performs telephone intake, patient registration, care management, and provider relations activities. CBH provides access to behavioral health services through a network of independently contracted health care professionals, behavioral health facilities, and chemical dependency facilities.

To arrange or confirm an inpatient referral or psychiatric consultation, please contact CBH at the Customer Service phone number on the patient’s ID card. Regular hours of operation for routine business are Monday through Friday, 8:30 a.m. to 5:00 p.m. CST. Additionally, advocates and care managers are available 24 hours a day for clinical emergencies. Additionally, advocates and care managers are available 24 hours a day for clinical emergencies by calling 1-844-883-2422 and selecting Behavioral Health.

For more information on CBH, or to find a participating behavioral health care professional, please visit Cigna’s website at [CignaforHCP.com](http://www.CignaforHCP.com).
National Ancillaries

Seton uses some of Cigna’s national ancillary programs which were developed to directly respond to member and client requests for access to cost-effective, quality services, and for being more informed on healthcare options.

To achieve these goals, we collaborate with select ancillaries like those listed below* to help ensure services are medically necessary and that quality care is received.

Program goals
- Expand access to quality health care professionals
- Increase quality of care and patient safety
- Educate members about their healthcare options
- Administer services in accordance with plan benefits and applicable coverage/reimbursement policies

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<th>Service</th>
<th>Ancillary</th>
<th>Description</th>
<th>Contact Information</th>
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<tr>
<td>Chiropractic Care</td>
<td>American Specialty Health</td>
<td>American Specialty Health (ASH) provides chiropractic network management, utilization management, and claims management services for individuals with Seton coverage in certain markets.</td>
<td>800.972.4226, americanspecialtyhealth.com</td>
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<td>High-technology radiology and diagnostic cardiology</td>
<td>eviCore healthcare</td>
<td>eviCore healthcare provides high-quality, cost-effective benefit management services to Seton members in most markets for outpatient, nonemergency, high-technology radiology (e.g., CT, MRI, and PET scans) and diagnostic cardiology services. Providers must request precertification through eviCore for affected services for their patients with Seton coverage. The radiology precertification process features improved customer service through the Informed Choice program. A specially-trained representative may contact individuals with Seton-administered coverage to inform them about the choices of available participating radiology service providers.</td>
<td>888.693.3211, myportal.medsolutions.com (precertification requests),medsolutions.com</td>
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<tr>
<td>Service</td>
<td>Ancillary</td>
<td>Description</td>
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| Sleep management services | CareCentrix    | CareCentrix provides a comprehensive Sleep Management Program for individuals with Seton coverage. As part of this program, CareCentrix provides individuals with access to its robust network of sleep therapy providers, which includes expanded access to sleep testing services in the comfort of the patient’s own home (and complements Seton’s network of sleep testing facilities). Health care professionals must request precertification for certain sleep testing services through CareCentrix. During the precertification process, we apply medical necessity and place-of-service determinations for these services. | 877.877.9899     
Cigna.SleepCCX.com                                      |
| Vision services          | Vision Services Plan | Routine eye exams are not covered under Seton medical coverage plans. Seton sells a separate product, Cigna Vision that covers routine eye exams and, in some cases, hardware. Vision Services Plan (VSP) is utilized for the Cigna Vision product. Individuals with the Cigna Vision product coverage may self-refer to a participating VSP health care professional for routine vision exams. If the individual also presents with a medical condition (diagnosis) that is considered a primary eye care diagnosis or has a primary eye care service as a result of that visit, the entire visit reverts to Seton Medical Plan coverage for payment by Seton. Individuals with Seton medical coverage may seek care for primary eye care from either a VSP provider or a Seton contracted Ophthalmologist in markets where Seton utilizes VSP. | 1.800.877.7195  
vsp.com                                   |

* List is not all-inclusive of every national ancillary provider. Ancillary providers do not manage services in all states and markets.
Member Information

Members receive a Seton ID card that includes an identification number, designated copayments information, coinsurance and deductibles, and the PCP name assigned to the member, if applicable. The ID card does not guarantee eligibility.

Review the ID card every time a member visits your office. To obtain eligibility information based on our current records:

- Log in to https://navinet.navimedix.com
- Call the Customer Service number on the member’s ID card

If a member does not have an ID card or enrollment form, call 1.844.883.2422.

Seton makes no representations or guarantees about the number of members referred to a health care professional. Seton also reserves the right to direct members to selected participating health care professionals and to influence members’ choice of participating health care professional.

These tools do not guarantee eligibility.

Alternate Member Identifier (AMI)

To help protect the privacy of members and prevent identity theft, Seton has phased out the use of Social Security numbers (SSN) as the member identifier. Use the identifier on the member’s ID card to submit claims and to inquire about eligibility or claim status.

Verification Options

For information on a member’s benefit plan, including copayments, coinsurance, or deductible amounts:

- Review the member’s ID card
- Log in to https://navinet.navimedix.com
- Call Customer Service 1.844.883.2422

Member Concern or Complaint

A member should contact Seton if they have a concern or complaint about administration, coverage or exclusions in their benefit plan, or service or care received. An attempt will be made to resolve the problem during the first telephone call. If a member is not satisfied with our response, he/she may follow the processes for submitting a complaint outlined in his/her benefit plan document. The process may include contact from a Seton representative to a health care professional to obtain information that may help in the resolution of the concern or complaint. This also provides an opportunity for the health care professional to respond to the concern or complaint.

Health Care Professional Cooperation

A member may ask for your assistance in regards to an appeal. We encourage you to assist the member by providing all relevant clinical records or a statement on behalf of the member.
Seton Insurance may contact you during the review and investigation of a member’s concern, complaint or appeal. Information or written statements may be requested. You are required to cooperate and assist with the resolution and appeals process within the time periods requested to help ensure a full and fair review and so Seton Insurance is compliant with applicable laws.

Either a member or a Seton Insurance representative may ask for your assistance with regard to an appeal, Quality of Care and/or Quality of Service complaint. To best address and/or resolve the member’s concern or appeal, we encourage timely submission of all relevant requested information.

If you believe an accelerated timeframe is needed and it meets the expedited criteria, an Expedited Appeal may be requested on behalf of the patient. An Expedited Appeal is available when:

- Member’s treating health care professional believes that processing the appeal request under the pre-service standard timeframes might jeopardize life, health, or ability to regain maximum functionality.
- Due to failure to authorize an admission or continuing inpatient hospital stay for a member who has received emergency services but has not been discharged from a facility.
- Member’s treating health care professional, with knowledge of the member’s medical condition, believes that by processing the appeal request under the pre-service standard timeframes it would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Contact Seton Insurance at the telephone number on the patient’s ID card to initiate the process and obtain expedited filing instructions.

**Health Insurance Portability and Accountability Act (HIPAA) of 1996**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 law ensures the portability of insurance coverage to protect patients from “prior condition” limits due to changes in employment or coverage.

The Administrative Simplification provisions of HIPAA include regulations about privacy, standard code sets and transactions, security and unique health identifiers. They were designed to safeguard a patients’ Protected Health Information (PHI), standardize the transmission of certain common transactions between health care entities, and standardize the medical codes used in those transactions. These standardization rules help reduce health care administrative costs.

We are committed to maintaining the confidentiality of member PHI. We have established policies and procedures to protect oral, written, and electronic PHI. Our Notice of Privacy Practices describes how we use and disclose PHI and advises members of their rights under federal and state laws. For a copy of the notice, visit www.setoninsurance.com.

Seton expects you to be compliant with HIPAA and other applicable confidentiality laws.

**Security Regulations**

The HIPAA standards for the security of electronic health information specifies a series of administrative, technical, and physical security procedures for covered entities to use to
ensure the confidentiality, integrity, and availability of electronic protected health information.

**National Provider Identifier**

The National Provider Identifier (NPI) is a unique identification number for use in standard health care transactions. It is a number issued to health care professionals and covered entities that transmit standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transactions (such as electronic claims and claim status inquiries). The Centers for Medicare & Medicaid Services (CMS) began issuing NPIs to health care professionals that applied and qualified in May 2005. Health care professionals and covered entities may apply for NPIs through the National Plan and Provider Enumeration System (NPPES) established by CMS for this purpose.

- Type 1 NPIs are assigned to individual practitioners, e.g., physicians, dentists, nurses, chiropractors, pharmacists, and physical therapists
- Type 2 NPIs are assigned to organizations, e.g., hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, and pharmacies

The NPI fulfills a requirement of HIPAA, and must be used by health plans, health care professionals, and health care EDI vendors in HIPAA standard electronic transactions. The NPI is intended to:

- Replace other identifiers previously used by health care professionals and assigned by payers (e.g., Unique Physician Identification Number [UPIN], Medicare or Medicaid numbers)
- Establish a national standard and unique identifier for all health care professionals
- Simplify healthcare system administration
- Encourage the electronic transmission of health care information

Seton accepts the NPI on standard HIPAA transactions as outlined below. This approach should not be confused with any guidance specific to Medicare claims requirements.

**837 Electronic Claims**

- The "Billing Provider" Taxpayer Identification Number (TIN) and NPI are required.
- Any additional health care professional identification on the claim, such as the "Rendering Provider" or "Referring Provider" must include the name and NPI when submitted.
- An organization may have more than one organization or type 2 NPI. Use the most appropriate organizational NPI as your primary identifier when submitting the "Billing Provider" on claims. The TIN must be submitted as the secondary provider identifier. This TIN is the number used on the Internal Revenue Service (IRS) form 1099, which is either the Employer Identification Number (EIN) for organizations, or the Social Security number (SSN) for individuals; both an EIN and SSN number should not be included concurrently. Other identifiers, such as Medicare provider number, are considered "legacy" identifiers and should not be included.
  - Submission of the “Billing Provider” TIN on the electronic claim is a HIPAA requirement. The National EDI Transaction Set Implementation Guide specifically states:
    - “If code XX - NPI’ is used, then either the Employer’s Identification Number or the Social Security Number of the provider must be carried in the REF in this loop. The number sent is the one which is used on the 1099.”
- Under HIPAA Accredited Standards Committee (ASC) X12 5010 standards, “Pay to
Provider” information is limited to an alternate address only. No additional identifiers, neither TIN nor NPI, are permitted. The “Pay to Provider” address is only needed if it is different from that of the “Billing Provider.”

- Seton will reject electronic claims received without a NPI unless the submitter is ineligible to receive a NPI. If you are not eligible to receive a NPI, notify Seton by updating your demographics.
- As with any change to your billing process, if you or your organization plan to change the way claims are submitted to Seton as a result of your NPI implementation or enumeration, please notify Seton of this change. One example would be an organization that has enumerated multiple NPI subparts and will start to bill using the “new” subpart health care professionals.

835 Electronic Remittance Advice

- For claims paid by check or EFT with TIN bulking, we group the claims within the 835 remittance by the “Billing Provider” NPI submitted on the original claim(s). A Provider Summary (TS3) field is added to the 835 and includes the “Billing Provider” NPI to help health care professionals easily reconcile their payments.
- For claims paid by EFT with NPI bulking, a separate 835 is sent for each NPI with the “Billing Provider” NPI returned as the “Payee” NPI. A Provider Summary (TS3) field is also added to the 835 and will include the “Billing Provider” NPI to help health care professionals easily reconcile their payments.
- The NPI for the “Rendering Provider” is included in the 835 regardless of bulking preference, if the “Rendering Provider” NPI was submitted on the 837 electronic claim.

Real-Time Request Transactions (270, 276, 278)

- All eligibility and benefit inquiries (270) transactions should be submitted with either a type 1 (individual) or type 2 (organizational) NPI. We will also accept a 270 submitted with a TIN.
- For professional or dental claim status inquiries (276), the “Billing Provider” or “Rendering Provider” NPI from the submitted claim should be used to inquire on claim status.
- For institutional claim status inquiries (276), the “Billing Provider” NPI from the submitted claim should be used to inquire on claim status.
- For all claim types, we will also continue to accept claim status inquiries (276) using the TIN from the submitted claim.
- Health Care Services Review — Request for Review (278) transactions should include the NPI or TIN to identify any health care professionals included in the request.
- Health care professionals should contact their EDI vendor for details regarding the submission of NPI on these transactions.

Seton Members’ Rights and Responsibilities Statement

As a Seton member, you have certain rights and responsibilities.

You have the right to:

- Receive coverage for the medical benefits and treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
- Receive the understandable information you need about your health benefit plan including information about services that are covered and not covered and any costs that you will be responsible for paying.
- Obtain understandable information about Seton’s programs and services, including the qualifications of clinical staff that support Seton wellness and similar programs and any contractual relationships.
- Have access to current information on in-network doctors, health care professionals, hospitals and places you can receive care and information about a particular health care professional’s education, training and practice.
- Select a primary care doctor for yourself and each covered member of your family, and change your primary care doctor for any reason. However, many benefit plans do not require that you select a primary care doctor.
- Have your personal identifiable data and medical information kept confidential by Seton and your health care professional, know who has access to your information, and know the procedures used to ensure security, privacy and confidentiality. Seton honors the confidentiality of its members’ information and adheres to all federal and state regulations regarding confidentiality and the release of personal health information.
- Participate with your health care professional in health decisions and have your health care professional give you information about your medical condition and your treatment options, regardless of coverage or cost. You have the right to receive this information in terms and language you understand.
- Learn about any care you receive. You should be advised of who is available to assist you with any special Seton programs or services you receive and who can assist you with any requests to change programs or services. You should be asked for your consent for all care, unless there is an emergency and your life and health are in serious danger.
- Refuse medical care and disenroll from programs/services offered by Seton. If you refuse medical care, your health care professional should tell you what might happen. We urge you to discuss your concerns about care with your primary care doctor or other participating health care professional. Your doctor or health care professional will give you advice, but you will have the final decision.
- Be heard. Our complaint-handling process is designed to: hear and act on your complaint or concern about Seton and/or the quality of care you receive from health care professionals and the various places you receive care in our network; provide a courteous, prompt response; and guide you through our grievance process if you do not agree with our decision. Seton strives to resolve your complaint on initial contact and in a manner that is consistent with your applicable benefit plan.
- Know and make recommendations regarding our policies that affect your rights and responsibilities. If you have recommendations or concerns, please call Customer Service at the toll-free number on your ID card.

You Have the Responsibility to:

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

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

This information pertains to physicians and other health care professionals only.

Cigna Pharmacy is the prescription drug benefit program for Seton Insurance plans. In order to be covered, members generally are required to purchase prescription drugs from Cigna participating pharmacies or from Cigna Home Delivery Pharmacy. Drugs are supplied per prescription order or refilled in quantities normally prescribed up to a 30-day supply or as defined by Cigna Pharmacy, the Food and Drug Administration (FDA) or applicable law. Up to a 90-day supply of maintenance medication may be dispensed through the home delivery prescription drug program (Cigna Home Delivery Pharmacy) or may be obtained from participating pharmacies if the member’s benefit plan provides for a 90-day supply at a local retail pharmacy.

Cigna Pharmacy requires that generic equivalents be dispensed for brand-name drugs as available and appropriate in the clinical judgment of a health care professional. Members who prefer a brand-name drug rather than its generic equivalent may be subject to a higher copayment.

Members who have a Cigna Pharmacy benefit are enrolled in the Three-tier plan

Seton Members

Members in the three-tier prescription drug plan have three copayment levels, depending on a drug’s assigned category on the Cigna Pharmacy prescription drug list or formulary. Generic or first-tier drugs have the lowest copayment; preferred brand-name drugs with no generic equivalent are typically considered second-tier drugs and have a slightly higher copayment; and drugs in the third-tier have the highest copayment. Third-tier drugs include brand names that have equally effective and less-costly generic equivalents or have one or more preferred brand-name options.

Preventive Prescription Drug Option

Under some plans that have a deductible, members may not be required to pay the deductible for preventive medications. The member would only be responsible for the other out of pocket cost, typically copayments or coinsurance. Preventive medications are those prescribed to prevent the occurrence of a disease or condition for those members with risk factors. Preventive medications can include those used for the prevention of conditions such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke, and prenatal nutrient deficiency. Preventive medications can be found within the online Drug Lists on Cigna.com.

If you have questions about our Prescription Drug Program, call 1.800.325.1404

Prescription Drug List

This information pertains to physicians and other health care professionals only.

- The Prescription Drug List (PDL) is a subset of the top drugs and therapeutic classes from the Cigna Pharmacy drug list. This preferred list of FDA-approved medications is the foundation of the Cigna Pharmacy prescription drug program. You may access the entire drug list online at CignaforHCP.com > Resources > Drug List > Select
Performance Drug List or request a paper copy by calling 1.800.325.1404.

Medications Requiring Precertification

Participating health care professionals and participating pharmacies in the Cigna Pharmacy network are responsible for following the Cigna Prescription Drug List (PDL) outpatient drug formulary. If a generic or preferred drug should not be prescribed in your medical judgment for a member in a closed-formulary benefit plan, due to non-availability, or if the prescribed drug is one of the few medications on the PDL that require prior approval of coverage, you are required to contact the Cigna Pharmacy service center to request precertification for coverage.

You have several options for submitting prior authorization requests.

- Fax a completed prescription coverage request to:
  - Cigna Pharmacy 1.800.390.9745
- Prescriptions can be sent using your ePrescribing software.
  - Select pharmacy name: Cigna Home Delivery Pharmacy
- PromptPA – an easy-to-use web-based tool: The direct link is https://cigna.promptpa.com/. The path through cignaforhcp.com without logging in:
  - Resources>Forms Center>Pharmacy Forms>Online Submission
- Call: 1.800.Cigna24 (244.6224)

All information fields must be complete and legible on the submitted request. The review process may take 48 hours. Incomplete forms will be denied or returned for illegible or missing information. Requests marked as urgent will be reviewed the same day they are received.

A copy of the Cigna Pharmacy prescription coverage request form is available at CignaforHCP.com > Resources > Pharmacy Resources > Communications > Prior Authorization Forms or CignaforHCP.com > Resources > Forms Center > Prescription Forms > General Prior Authorization.

PromptPA - Medication prior authorization now available online:

PromptPA is a new web-based capability offering you a convenient, easy-to-use tool to obtain prior authorization of medications online. This online option is available for drugs covered under the Cigna Pharmacy benefit. The direct link is https://cigna.promptpa.com/. The path through cignaforhcp.com without logging in:

Medications Typically Excluded from the Prescription Benefit

This Information Pertains to Physicians and Other Health Care Professionals Only.

Coverage for prescription drugs and related supplies are subject to the terms and conditions of a member’s benefit plan, including but not limited to the “exclusions and limitations” section of the benefit plan. The following are typically excluded from the prescription benefit:

- Any drugs or medications available over the counter that do not require a prescription by federal or state law, and any drug or medication that has a chemical equivalent i.e. same active ingredient and equivalent dosage to an over the counter drug or medication other than insulin.
- Medications that are therapeutically equivalent as determined by the Cigna Pharmacy and Therapeutics Committee in which at least one of the medications within the class
is available over the counter. [examples include Rx equivalents to OTC Allegra, Claritin and Zyrtec (Allegra D, Clarinex, Xyzal) and Rx equivalents to OTC Prevacid, Prilosec, Zantac (Aciphex, Kapidex, Nexium, Aclid, Pepcid, Zantac)]; unless indicated as covered under the prescriptions drug list.

- Any injectable medications that require Health Care Professional supervision and are not typically considered self-administered medications. The following are examples of Health Care Professional supervised medications:
  - Injectables used to treat hemophilia and RSV (respiratory syncytial virus)
  - Chemotherapy injectables

- Any drugs that are experimental or investigational, within the meaning set forth in the Agreement.

- Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is prescribed for the treatment of a life-threatening or chronic and seriously debilitating condition, the drug is Medically Necessary to treat that condition, and the drug has been recognized for treatment of that condition by one of the following:
  - The American Hospital Formulary Service Drug Information
  - Two English language peer reviewed medical bio-medical journals that present data supporting the proposed off-label use or uses as generally safe and effective for the proposed indication.

- Any prescription and non-prescription supplies (such as ostomy supplies), devices, and appliances, except as covered in this Rider. Please refer to Definitions, Related Supplies, for covered supplies.

- Any prescription vitamins (other than pre-natal vitamins), dietary supplements and fluoride products that are not subject to the no cost sharing preventive requirements under PPACA.

- Prescription Drugs used for cosmetic purposes, such as, drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.

- Any diet pills or appetite suppressants (anorectics) unless the member’s benefit plan includes this coverage.

- Prescription smoking cessation products unless the member’s benefit plan includes this coverage or coverage is required at no cost sharing due to PPACA.

- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for prevention of travel-related disease.

- Replacement of Prescription Drugs and Related Supplies due to loss or theft beyond two (2) incidents per Calendar Year. Each incident may include one or more prescriptions.

- Medications used to enhance athletic performance.

- Any medications used for treatment of sexual dysfunction (male or female), including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido unless the member’s benefit plan includes this coverage.

- Medications that are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution that operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.

- Prescriptions more than one year from the original date of issue.

- Any infertility drugs or infertility injections, unless the member’s benefit plan includes this coverage.
Cigna Home Delivery Pharmacy℠

This information pertains to physicians and other health care professionals only.
Cigna provides a home delivery pharmacy benefit designed for members who take medication on a regular basis to help them manage chronic or long-term conditions. When members use Cigna Home Delivery Pharmacy, they may reduce their out-of-pocket costs by obtaining up to a 90-day supply of their medications in one fill. The 90-day supply maximum is subject to health care provider judgment and FDA dosage recommendations. In cases where a 90-day supply is not recommended by the FDA, prescribing provider, or Cigna, the home delivery quantity will be limited.

A generic equivalent drug is automatically substituted unless you indicate, “dispense as written.” Members or healthcare professionals may contact Cigna Home Delivery Pharmacy by calling 1-800-325-1404. Health Care Professionals may access information about Cigna Home Delivery Pharmacy online at CignaforHCP.com > Resources > Pharmacy Resources > Cigna Home Delivery Pharmacy.

Pharmacy Clinical Support Programs

Medication Safety Program for Narcotic Medications

Cigna’s Medication Safety Program leverages a quarterly, retrospective review of pharmacy claims data to help identify those individuals with prescription patterns that may be indicative of fraud or substance abuse.

Our program analyzes individuals’ prescription drug histories, and the number of health care provider and pharmacy visits over a specific time period and creates detailed profiles. With these profiles, we identify individuals who may benefit from further discussion, evaluation or action with their health care providers about our findings.

CoachRx

CoachRx is Cigna Pharmacy Management’s outcome improvement program designed to help individuals stay adherent to taking their medications as prescribed. The CoachRx program includes a team of pharmacists that members can talk with to learn about medication options, side effects, and barriers to medication adherence, and possible interactions. CoachRx pharmacists can help facilitate a switch to Cigna Home Delivery Pharmacy. Members can reach the CoachRx team at 1.800.835.8981.

Also, members can access a range of tools online at Cigna.com/Coachrx to help them stay healthy, including automatic text and email reminders, a medication adherence barrier assessment, and educational materials.

Specialty Pharmacy Prescription Drug Program

This information pertains to physicians and other health care professionals only.

Cigna Specialty Pharmacy Management is the national preferred source for specialty medications and operates as a part of Cigna’s wholly owned dispensing pharmacy, Cigna Home Delivery Pharmacy. Cigna Specialty Pharmacy Management dispenses specialty medications covered under the pharmacy and medical benefit. Cigna Specialty Pharmacy Management can provide most specialty pharmacy medications for a variety of therapeutic classes, including injectable medications, for the treatment of conditions such as:
Additionally, Cigna’s Specialty Pharmacy Condition Specific Teams provide specialized assistance for patients. Conditions include multiple sclerosis, inflammatory diseases, hepatitis C, cancer, respiratory disorders, HIV, infertility, and transplants. Patient advocates provide patients with a thorough understanding of the process and help patients understand how to manage their condition, take their medication as indicated, and ensure they have access to all known resources for support. The Condition Specific Teams, which include registered nurses, proactively reach out to patients and anticipate their needs.

Cigna specialty medication prescription orders are shipped confidentially and delivered by first-class mail to the destination indicated on the prescription order form. Expedited carrier and special packaging is used for medications requiring refrigeration and overnight delivery at no additional charge.

Immunizations are not offered through the specialty pharmacy prescription program. Cigna Specialty Pharmacy also offers a Clinical Infusion Program to support both patients and providers. Clinicians provide patient education on lifestyle changes, medication administration, adherence education, and any anticipated infusion issues such as leakage and infusion rates, following an initial prescription. Follow-up outreach is made 72 hours after the initial therapy to assess for infusion issues and adherence to treatment plan. The Cigna clinician will outreach to the patient’s health care provider to determine if the treatment plan will continue as written or if changes need to be made. They will help coordinate follow up activity.

Ordering from Cigna Specialty Pharmacy
Designed to simplify administrative requirements for you and your office staff, the Cigna Specialty Pharmacy Program makes ordering specialty pharmacy medications easy. When calling or faxing orders to Cigna Specialty Pharmacy Management, the pharmacy team will:

- Verify member eligibility
- Obtain precertification and prior authorization, as applicable
- Facilitate coordination of care
- Bill Seton directly
- Provide patient education materials and supplies when requested
- Facilitate financial assistance as needed and appropriate
- Coordinate shipping to health care provider or member

Specialty Pharmacy Orders
Information on Cigna Specialty Pharmacy Management as well as the general injectable and medication-specific order forms can be found on Cigna.com > Health Care Professional > Pharmacy.
Contact Cigna Specialty Pharmacy Management for specialty and injectable medication prescriptions as follows:

New Orders
- Fax a completed general specialty and injectable medication fax order form to 1.800.351.3616.
- Telephone specialty and injectable medication prescription information to 1.800.351.3606.

Transfers
- Fax a completed general specialty and injectable medication fax order form to 1.800.351.3616 and indicate which pharmacy currently holds the prescription, including all necessary pharmacy contact information.
- Call 1.800.351.3606 and speak with a Cigna Specialty Pharmacy pharmacist to transfer the prescription.

A Cigna Specialty Pharmacy Pharmacist will review the order form and will coordinate with a centralized team to request precertification of coverage, when required.

Preferred Specialty Pharmaceutical List*
Cigna maintains a Preferred Specialty Pharmaceutical List. The decision of which drugs to prescribe is up to you based on your clinical judgment. Coverage is not limited to the preferred drug. All medications included on the list are available through Cigna specialty pharmacy.

Access the most current list, information on the program or download the Cigna medication order forms by logging in to Cigna.com > Health Care Professional > Pharmacy or by accessing the following link: Cigna.com/customer_care/healthcare_professional/pharmacy/index.html.

To download the Cigna specialty pharmacy services drug specific fax order forms, log in to Cigna.com > Health Care Professional > Pharmacy or by accessing the following link: Cigna.com/customer_care/healthcare_professional/pharmacy/specialty_drug.html.

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<thead>
<tr>
<th>Growth Hormones</th>
<th>Hepatitis C Antivirals</th>
<th>Biologic Immunomodulator Agents</th>
<th>Multiple Sclerosis Agents</th>
<th>Infertility</th>
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<tr>
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- This list represents the National Drug List. Certain drugs may be listed differently on other Cigna drug lists.
- Please contact Customer Service to find out if this Preferred Specialty Pharmaceutical List applies to your particular drug list.
- Cigna reserves the right to make changes to this Preferred Specialty Pharmaceutical List without notice.
Coverage for Self-Administered Injectable Medications

A defined list of injectable medications are not covered under the Seton medical plan but are covered under the Cigna Pharmacy Plan.

In order to be covered under the Cigna Pharmacy Plan, these medications must be obtained from either a retail pharmacy or Cigna Specialty Pharmacy Management subject to the terms of the plan. If required, you may continue to administer these medications and you will be reimbursed for related administration costs. However, the medical plan will not reimburse you for the cost of these medications. If your patient’s pharmacy benefit is provided by a company other than Cigna, contact the pharmacy benefit company for information about coverage for these medications.

Self-administered injectable medications covered under a standard Cigna Pharmacy plan at the time of this publication are summarized below. If you have questions about the coverage of a certain medication, contact Customer Service at the telephone number on the patient’s ID card.

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<tr>
<th>Brand Name</th>
<th>Actimmune</th>
<th>Apokyn</th>
<th>Arcalyst</th>
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<td>Humira</td>
<td>Increlex</td>
<td>Infergen</td>
<td>Ketorolac</td>
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<td>Kineret</td>
<td>Kynamro</td>
<td>Myalept</td>
<td>Norditropin Nordiflex</td>
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<tr>
<td>Nutropin</td>
<td>Omnitrope</td>
<td>Orenzia</td>
<td>Otrexup</td>
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<tr>
<td>Peg Intron</td>
<td>Pegasys</td>
<td>Plegridy</td>
<td>Rasuvo</td>
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<tr>
<td>Rebif</td>
<td>Relistor</td>
<td>Saizen</td>
<td>Serostim</td>
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<tr>
<td>Signifor</td>
<td>Simponi</td>
<td>Somavert</td>
<td>Stelara</td>
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<tr>
<td>Sylatron</td>
<td>Tev-Tropin</td>
<td>Xolair</td>
<td>Zortive</td>
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</tbody>
</table>

_Actual coverage is subject to the terms of the particular member’s benefit plan._

Cigna Specialty Pharmacy Management Offers Drug Therapy Management

TheraCare® is a support program for Seton members who use specialty medications for certain chronic conditions.

TheraCare provides added support to members to help them better understand their condition, medications, side effects, and the importance of taking their medication as prescribed. We have found in many cases, that patients’ health and quality of life are improved when they comply with their treatment plan.

If the member has any of the following conditions and uses a specialty medication for it, they
may be eligible for TheraCare:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Enzyme disorders</th>
<th>Need for Respiratory Syncytial Virus prophylaxis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer: oral oncology agents</td>
<td>Hepatitis C</td>
<td></td>
</tr>
<tr>
<td>Pulmonary arterial hypertension</td>
<td>Chronic Plaque Psoriasis</td>
<td>Growth hormone deficiency</td>
</tr>
<tr>
<td>Ankylosing spondylitis</td>
<td>Psoriasis</td>
<td>Hemophilia</td>
</tr>
<tr>
<td>Crohn's disease</td>
<td>Psoriatic arthritis</td>
<td>Juvenile Idiopathic Arthritis</td>
</tr>
<tr>
<td>Asthma</td>
<td>Multiple sclerosis</td>
<td>Uveitis</td>
</tr>
</tbody>
</table>

Patients identified for program participation are contacted via telephone by Therapy Support Coordinators who educate them on the program and encourage their participation. Patients who agree to participate are enrolled in TheraCare and can participate in a series of telephone and mail outreach conducted by Therapy Support Coordinators and Registered Nurses (RNs).

The outreach includes educating the patient about their condition(s), their medication(s) and potential side effects during periodic calls based on the needs of the patient.

Throughout therapy, the program monitors for prior authorizations that are set to expire and facilitates the re-authorization process with the goal of avoiding gaps in therapy approval and risk for non-adherence. Pharmacists are also available for patient consultation when needed.

**Who is eligible?** To be eligible for TheraCare a member needs to be covered by an employer health benefit plan that has elected to offer the program to their employees and dependents. To determine if your patient has access to TheraCare, please call the TheraCare team at 1.800.633.6521.

**What are the benefits for my patient?** There are many benefits to your patient when they choose to participate in TheraCare. The program takes an integrated approach to care by focusing on the patient’s total health, not just the specialty condition. After joining TheraCare, your patient will be assigned a personalized team, consisting of a therapy support coordinator and nurse, who will:

- Monitor your patient’s side effects and help them to work through them
- Help your patient to reduce any roadblocks standing in the way of taking their medication as you prescribed
- Coordinate new prescription orders and refills through Cigna Home Delivery Pharmacy
- Assess adherence for appropriate laboratory monitoring of the disease
- Organize in-home training for your patient on how to use their self-injectable medications if needed

TheraCare understands your professional medical judgment is most important in the treatment of your patient. The goal is to work collaboratively with you to maximize your patient’s treatment by providing an added level of support and anticipating their needs. With the patient’s consent, TheraCare will contact you with any concerns we have while working with your patient.

**How will the TheraCare team work with me?** The TheraCare program will work
collaboratively with you to help your patient maximize outcomes from the therapy you prescribe. If any issues are identified by the TheraCare team, you will be notified.

**How do I contact the TheraCare team?** The TheraCare team can be reached at 1.800.633.6521, Monday through Friday, between 10:00 am and 9:00 pm Eastern time.

Your patients with Seton coverage that are eligible to participate in TheraCare can find information about the program on the “My Plans – Pharmacy” screen of myCigna.com.

- myCigna.com also has a new section on the Pharmacy page under Additional Resources highlighting the TheraCare program, if available to that patient.
- In addition, the Cigna for Health Care Professionals website (CignaforHCP.com) has a section specific to Specialty Pharmacy Management to inform you whether medications require prior authorization under the pharmacy benefit and what specialty network is available to your patient.
Quality Management Program

The Quality Management Program provides direction and coordination of quality improvement and quality management activities across Seton departments, including Utilization Management, Contracting and Provider Services, Customer Service, and Claims.

The Quality Management Program outlines processes for measuring quality and provides guidance in initiating process improvement initiatives when deficiencies are identified. Quality studies are designed and documented to evaluate the quality and appropriateness of care and service provided to members. Program activities include:

- Review performance against the key quality indicators as identified in the quality work plan.
- Provide information about the quality and cost efficiency of participating health care professionals and hospitals to facilitate more informed decision-making by the member we serve.
- Evaluate member and health care professional satisfaction information.
- Evaluate access to services provided by the plan and its contracted health care professionals and hospitals.

When an opportunity for improvement is identified through an evaluation of performance indicators or from other sources, Seton uses a problem solving approach, the Continuous Quality Improvement (CQI) Process. If you would like more information about our Quality Management Program, including a more detailed description of the program and a report on the progress in meeting Seton goals, please call 1.877.312.9835.

Seton invites our contracted health care professionals to actively participate in several of our quality committees, including the Quality Improvement Committee, the Peer Review Committee, and the Credentialing Committee. Our commitment to quality is demonstrated through the program activities described in our Clinical Care Guidelines below.

Clinical Care Guidelines

This Information Pertains to Physicians and Other Health Care Professionals Only.

Clinical care guidelines, as outlined below, may be used as a resource as you screen and treat various conditions. Log in to the portal at https://navinet.navimedix.com.

- A Guide to Cigna’s Preventive Benefits for Health Care Professionals
- Clinical guidelines for behavioral health, including depression, attention-deficit and hyperactivity disorder and alcohol screening
- Chronic Condition Management (Cigna’s Disease Management Program) adopted clinical practice guidelines from nationally recognized professional sources that provide evidence-based clinical support and background.

To view information on Chronic Condition Management, log in to the portal at https://navinet.navimedix.com.

Peer Review

This information pertains to physicians and other health care professionals only.

Peer review is used to help uncover substandard or inappropriate care, or inappropriate
professional behavior, by a practitioner. If the findings of the confidential peer review process indicate substandard or inappropriate member care or inappropriate professional conduct, Seton will take appropriate action. The actions that may be taken include development of a corrective action plan, education, counseling, monitoring, and trending of data, recredentialing within one year or less, notification to appropriate state and/or federal bodies, and limitation of or termination from participation. Peer review information is generally considered privileged and confidential under applicable state and federal laws.

Medical and Behavioral Continuity and Coordination of Care

This information pertains to physicians and other health care professionals only.

To facilitate continuous and appropriate care for members, and to strengthen industry-wide continuity and coordination of care among health care professionals, the quality program monitors, assesses, and may identify opportunities for members or providers to take action and improve upon continuity and coordination of care across healthcare network settings and transitions in those settings. Assessment of continuity and coordination of care collaboration may include, but is not limited to, measurement of the following as demonstrated using surveys, committee discussions reflected in minutes, medical record review, and data analysis. Examples of monitoring may include:

- Exchange of information in an effective, timely, and confidential manner.
- Notification and movement of members from a terminated practitioner.
- Monitoring of members who qualify for continued access to a practitioner terminated for other than quality reasons.
- Encouraging members to forward copies of their medical records to their new primary care physician (PCP) when PCP changes are made.
- Following are examples of what may be collected and measured, but are not inclusive of the types of data that may be collected by Seton Quality Management staff to evaluate continuity and coordination of care:
  - Home Health Start of Care Timeliness
    - Percentage of Home Health Cases Started when appropriate
  - Emergency Department (ED) Care and Primary Care Physician Sites
    - Percentage of Seton members experiencing ED re-admissions due to lack of follow up with their Primary Care Physician.
  - Member Outreach Following Discharge from an Inpatient Facility
    - Percentage of post-hospital discharged Seton members completing a return visit with Primary Care Physician or specialist as appropriate
  - Ambulatory Medical Record Review Continuity of Care Indicators
    - Specialist and Ancillary Consultations are reviewed by Primary Care Physicians
    - Labs and Diagnostics are reviewed by Primary Care Physicians
    - Adverse Event and Quality of Care Complaint Monitoring with root cause of continuity and coordination of care to identify trends or individual interventions required

Based upon conclusions for each monitoring activity, Seton will communicate results and analysis to practitioners and facilities if opportunities for improvement are identified.

Behavioral and Medical Continuity and Coordination of Care

To facilitate continuity and coordination of care for members among behavioral and medical practitioners and physicians, Seton, in collaboration with our behavioral health partners,
fosters and supports programs that monitor continuity and coordination of behavioral care through assessment of one or more of the following:

- Appropriate communication between behavioral and medical practitioners.
  - Appropriate health care professional screening/diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.
- Evaluation of the appropriate uses of psychotropic medications.
- Management of treatment access and follow-up for members with coexisting medical and behavioral health disorders.
- Implementation of a primary or secondary behavioral health preventive program.
- Address the special needs of members with severe and persistent mental illness.

**Ambulatory Medical Record Review (AMRR)**

**This information pertains to physicians and other health care professionals only.**

As part of our Quality Improvement Program, and in select markets as required by state regulation, Seton may select a random sample of participating primary care physicians for medical record review. The review assists in quality oversight, but does not define standards of care or replace the clinical judgment of treating health care providers.

The objectives of the AMRR are as follows:

- Determine the structural integrity and irretrievability of medical records
- Evaluate the adequacy of information necessary to provide appropriate care to members
- Enhance patient safety by focusing on continuity and coordination of care
- Improve documentation of the clinical care delivered to Seton members

Medical records are randomly selected for review from health care providers and for members who have been enrolled in Seton for a minimum of six months, and who have had a minimum of two visits within the last 12 months. Physicians receive a notification letter from Seton when they are selected to participate in the review.

Physician scores are aggregated and analyzed at a market level. Indicators are individually trended. The goal is an aggregate score of at least 85 percent compliance among records reviewed. Study results and opportunities for improvement are reported to the appropriate quality committee. Feedback of AMRR results and areas for improvement are shared with primary care physicians.

**Pharmacy and Therapeutics Review**

**This information pertains to physicians and other health care professionals only.**

Seton uses Cigna for its pharmacy benefit and Cigna has a National Pharmacy and Therapeutics (P&T) Committee. Committee members include practicing physicians and clinical pharmacists from local markets across the U.S., Cigna medical and pharmacy directors, and outside pharmacology consultants. The committee meets quarterly to examine the safety and efficacy of new drugs and biologics as well as clinical updates to drugs and biologics previously reviewed by the committee.

The drug evaluation process employed by the Pharmacy and Therapeutics Committee is an
evidence-based approach to clinical literature. A comprehensive drug monograph is prepared by an external university-based drug information service and presented to the committee.

Through the Pharmacy and Therapeutics Committee evaluation process, drugs are determined to be clinically inferior, superior or neutral to alternative therapies given data on safety and efficacy. The committee considers how well each drug works and potential side effects for the indicated treatment population, as well as identifies any subsets of the population with greater or less efficacy and/or safety. All Food and Drug Administration (FDA) newly approved drugs receive a determination of Non Preferred until P&T Committee review can be held. The P&T Committee reviews priority approvals, as designated by the FDA, within six (6) months of their approval or launch to the market. Non-priority designated FDA approvals are reviewed after at least six (6) months from the FDA approval or market launch to allow for additional post marketing publications regarding a drugs clinical efficacy or safety to be evaluated. The Prescription Drug List generally considers any non-excluded generic drug to be preferred at the lowest tiers of a benefit plan. Preferred Brand drugs are not necessarily clinically superior to alternative therapies and may be selected on non-clinical factors such as cost.

Clinical and Quality Improvement Studies

This information pertains to physicians and other health care professionals only.

Clinical and quality improvement studies help evaluate quality and appropriateness of care provided to patients. Topics for evaluation and special studies are chosen based on relevant demographics and epidemiological characteristics of members. Clinical studies review issues such as preventive care/HEDIS® measures against preventive care guidelines and compliance with treatment standards for depression. Scientifically based criteria are used for specific conditions, as developed by nationally recognized organizations and adopted by Seton. Population-based assessment is conducted whenever appropriate, supplemented by focused medical record review and/or patient surveys. Data are collected, reviewed, and analyzed for trends and opportunities for improvement.

Physician and Hospital Performance Evaluation

We may evaluate the performance of select health care provider specialties and hospitals, and provide this information to individuals in order to help facilitate more informed decision-making when they select providers and hospitals for the provision of their care. We may provide performance feedback to help you assess and enhance performance around:

- Quality of care
- Quality of service
- Cost-efficiency

Such performance feedback may be based on surveys, review of medical records, and analysis of medical utilization. We are available to answer any questions you may have about this feedback.

Preventive Care

Seton’s preventive care coverage complies with the Patient Protection and Affordable Care Act (PPACA). Services designated as preventive care include periodic well visits, routine immunizations and certain designated screenings for symptom-free or disease-free members. They also include designated services for individuals at increased risk for a particular disease.
The PPACA requires health plans to cover preventive care services with no patient cost sharing, unless the plan qualifies under the grandfather provision or for an exemption. The majority of Seton Insurance plans fall under the PPACA, and cover the full cost of preventive care services. Typically, these services must be provided by in-network health care professionals.

To determine whether or not your patient’s Seton administered plan covers preventive care and at what coverage level (100% or patient cost share), visit the secure portal at https://navinet.navimedix.com to verify benefit and eligibility information, or call 1.844.883.2422.

**Preventive Care Services**

The PPACA has designated specific resources that identify the preventive services required for coverage by the Act. U.S. Preventive Services Task Force (USPSTF) A and B recommendations:

- Advisory Committee on Immunization Practices (ACIP) recommendations that have been adopted by the Director of the Centers for Disease Control. Recommendations of the ACIP appear in three immunization schedules
- Comprehensive Women’s Health Guidelines supported by the Health Resources and Services Administration (HRSA)
- Guidelines for infants, children, and adolescents appear in two charts: the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care and the Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children.

**Coding for Preventive Services**

Correctly coding preventive care services is essential for receiving accurate payment. Submit the preventive care services with an ICD-10 code that represents health services encounters that are not for the treatment of illness or injury.

- Place the ICD-10 code in the first diagnosis position of the claim form.
- Preventive care service claims submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim will be paid as applicable under normal medical benefits rather than preventive care coverage.
- Non-preventive care services incorrectly coded as “Preventive Medicine Evaluation and Management Services” will not be covered as preventive care.

**High-Risk Maternity Case Management**

Our high-risk maternity case management program is available to Seton Insurance medical plan enrollees at no additional cost. High-risk maternity case management is focused on providing support for women who have been identified as being potentially at risk for pregnancy-related complications and prenatal hospitalizations because of co-morbid medical conditions. Case managers have condition-specific tools available to them to provide guidance in assessment, intervention, and documentation of key interventions to help close any possible gaps in care and support you in caring for these women. When women are hospitalized for non-delivery maternity admissions, these high-risk maternity case managers assume the responsibility of inpatient case management (concurrent review), discharge planning, and post-discharge outreach and follow-up.
Oncology Programs

Oncology Case Management

Our oncology case management program is available to Seton medical plan enrollees at no additional cost, and focuses on improving the quality of care and life for members with cancer. Specialty case managers work with members, their doctors, and their families to help ensure that the members are informed and involved in treatment decisions, and that they are compliant with those decisions.

Part of the overall goal is to reduce avoidable hospitalizations and emergency room visits due to complications from chemotherapy and inadequate pain management. Working with a Seton oncology case management nurse is encouraged for members who are in active treatment, such as chemotherapy and radiation therapy, with or without complications.

Chronic Condition Management

Our whole person solution weaves all the health issues affecting a chronic member into one ongoing conversation. Seton’s chronic condition management solution provides health management tailored to each member’s preferences. And it is all delivered through the continuous, personalized support of a dedicated health advocate. These advocates:

- Support members with their recommended treatment and symptom management plans
- Empower members to take actions regarding opportunity of care to help mitigate negative health consequences
- Collaborate in the development of individual action plans to assist the member in reaching their healthy lifestyle goals

The primary goal of the program is to help members improve the quality of their lives and overall health. Seton’s chronic condition management program is a primary advocate model; once a member and health advocate relationship is formed, the health advocate remains that member’s health advocate for future needs or concerns.

To identify members who may benefit from chronic condition coaching, we leverage multiple data sources to help identify potential candidates. We also identify potential program members through physician, medical management, pharmacy, and other health advocacy program referrals, as well as individual self-referrals. We outreach to identify program candidates to encourage participation in the chronic condition management program.

Outreach is triggered by the following chronic conditions:

- Acute myocardial infarction
- Angina
- Asthma
- Chronic obstructive pulmonary disease (emphysema and chronic bronchitis)
- Congestive heart failure
- Coronary artery disease
- Diabetes, type 1
- Diabetes, type 2
- Heart disease
- Obesity
- Peripheral arterial disease (PAD)
Integration of member information, used to determine key clinical targets, aligns resources to the members’ needs. Seton’s process of ongoing assessment and segmentation gives care coordination staff the ability to assist members in addressing their needs, helping to avoid potential risks.

Supported by evidence-based medical guidelines and the most influential behavioral techniques, our care coordinators help program members manage many aspects of their personal health. This includes adherence to medications, understanding and managing risk factors, maintaining up-to-date screenings, participating in monitoring tests, treatment decision support, pre- and post-hospitalization outreach, lifestyle management coaching, and more. In addition to telephone coaching, online self-guided assistance is also available.

From a health care provider’s perspective, the Seton team is a resource to help facilitate compliance with the treatment plan that has been created to aid in recovery and to help prevent complications. Our goal is to educate patients about their health, support them in their relationship with you, and empower them to become active members in their own healthcare. We support the patient-provider relationship by helping to prepare members to have meaningful and educated interactions with their treating physicians and other members of their health care team.

To view information on our chronic condition management program, log in to the secure portal at https://navinet.navimedix.com.

Information provided includes:

- Detailed program description and supporting program materials with reference to how we identify and engage potential chronic condition members
- The evidence-based guidelines used for each condition of our programs
- Hours of operation and contact information, including telephone number, and email address

**Healthcare Effectiveness Data and Information Set (HEDIS®)**

**This information pertains to physicians and other health care professionals only.**

Healthcare Effectiveness Data and Information Set (HEDIS) measures are standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to improving health care quality. HEDIS is designed to help ensure consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS also includes the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a standardized survey of consumer experiences that evaluates plan performance in areas such as customer service, access to care, and claims processing. Individual HEDIS measures may also be used to evaluate the efficacy of health management systems, the impact of practice guidelines, and adherence to preventive health recommendations.

Seton annually compiles preventive and chronic health data according to HEDIS guidelines. HEDIS data is obtained from two sources: administrative systems and medical records. Administrative system data is derived from claim and encounter data. In order to help capture an accurate and comprehensive reflection of the care provided to members, Seton also audits a sample of medical records for some measures between February and May of each year.
The HEDIS data collection process is dependent on the cooperation and assistance of Seton’s network of physicians and health care professionals. The following is a highlight of the medical record process:

- Seton requests medical records from health care professionals for members chosen through a randomized sample selection process and identified through claims data.
- HEDIS medical record requests are sent by fax, letter, and secure e-mail. The request includes a list of members and the specific information required to meet the HEDIS specifications.
- HEDIS-related medical record information should be returned to Seton by fax, mail, or through a secure electronic medical record system within thirty days of the request.
- A follow-up telephone call may be necessary if additional information is needed.
- If health care professionals utilize copy service vendors, the health care professional should ensure that the copy service vendors submit requested records to Seton Insurance within thirty days of the request.

Failure to cooperate with the HEDIS data collection process is considered a breach under the terms of Seton participation agreements and may be grounds for termination from the network.

Your provider agreement provides for the release of medical record information to Seton for these quality projects without specific patient permission. If you have any questions or concerns, please review the guidelines on the HIPAA website at [cms.hhs.gov](http://cms.hhs.gov).

*HEDIS® is a registered trademark of NCQA

**HEDIS® Medical Record Review**

**This information pertains to physicians and other health care professionals only.**

The following standards are part of the record documentation and review process.

- HEDIS review auditors require copies of measure-specific documentation located in the actual medical record.
- HEDIS review auditors require a copy of the patient’s registration form or demographic sheet in the record verifying the patient’s name and date of birth.
- HEDIS measure documentation is time-specific. Requested records are for the prior year or earlier. (Example: HEDIS 2015 = calendar year 2014 or earlier.)
- Member names should appear clearly on the documentation.
- Member name changes due to marriage, divorce, adoption, etc. should be clearly documented in the medical record.
- Complete dates (mm/dd/yy) should be on each entry.
- Names of other specialists, physicians and/or facilities that treat patients should be documented.
- The immunization history should be included for children and adolescents. Request a copy of the school vaccine administration record and/or a copy of the previous PCP immunization history.
- For colorectal cancer screening, document the date when the diagnostic procedure was performed, and the results. Obtain the actual diagnostic reports for your records.
- For patients being monitored due to hypertension, document the diagnosis of hypertension and date, if known, in the patient’s medical history and/or in the problem list.
- Obtain all ophthalmologist or optometrist reports for dilated retinal exams for patients with diabetes. Ensure that results of the exam are clearly indicated in the report.
- Include the actual lab results in the medical record.
- For pediatric well-care visits, document dates of well-care visit(s) and physical(s), and any evidence of ongoing issues.
Texas Written SB 418 Verification

Definition

Services provided to fully insured members may be eligible for the written TX Verification process outlined in SB 418. The TX Verification process is separate from the telephonic process by which you may request member eligibility and benefit design information.

Protocol

Prior to issuing a TX Verification, the proposed service or services are reviewed for the following:

- Confirmation that member is eligible
- Prior authorization (if requested services/procedures appear on the required prior authorization list). All elective hospital confinements require prior authorization
- Confirmation that requested service/procedure is a covered benefit
- A summary of the member’s copays, coinsurance, deductible as applicable to proposed service

It is important to note that a TX SB 418 verification must be in writing. A written declination does not mean that the service will not be reimbursed. A declination means only that Seton is unable to verify payment in advance of the service being rendered.

How To Request TX Verification

TX Verification is available if the provider’s Texas contract has been renewed on or after August 16, 2003, the member is a Texas resident and the member participates in a fully insured plan. To request a TX Verification the participating provider must specifically request a TX Written Verification or a TX SB 418 Verification and provide the data elements required by Texas regulation, shown below:

- patient name;
- patient ID number, if included on an identification card issued by the HMO or preferred provider carrier;
- patient date of birth;
- name of enrollee or subscriber, if included on an identification card issued by the HMO or preferred provider carrier;
- patient relationship to enrollee or subscriber;
- presumptive diagnosis, if known, otherwise presenting symptoms;
- description of proposed procedure(s) or procedure code(s);
- place of service code where services will be provided and, if place of service is other than provider's office or provider's location, name of hospital or facility where proposed service will be provided;
- proposed date of service;
- group number, if included on an identification card issued by the HMO or preferred provider carrier;
- if known to the provider, name and contact information of any other carrier, including the name, address and telephone number, name of enrollee, plan or ID number, group number (if applicable), and group name (if applicable);
- name of provider providing the proposed services; and
- provider’s federal tax ID number.
TX Verification requests may be made by telephone, by fax or in writing. Contact Customer Service using the telephone number on the back of the member’s ID card. Customer Services also can supply a fax number or mailing address if you wish to request the verification by fax or by mail.

Within five calendar days (72 hours for urgent situations) of receiving the request for Verification, Seton will render a written decision. You may be informed of the decision orally, but a written confirmation also will be sent. The written Verification will be in force for 30 days from the date it is issued and the written Verification will include the date the Verification expires. A declination will include the reason the Verification is declined.

If the service in question requires prior authorization, the review for medical necessity and appropriateness will be conducted by clinical staff in accordance with TX regulations including Medical Director review and peer-to-peer discussion, if applicable. If prior authorization is required, you will receive the prior authorization decision in accordance with state utilization review regulations. The Verification (or Declination) decision will be sent separately from the prior authorization decision. Therefore, in certain instances, you will receive two decision letters.
Legal Statement

As a subsidiary of Seton Healthcare Family, a healing ministry of the Catholic Church, Seton Insurance Company and its affiliates do not promote or condone services, benefits or procedures that are contrary to or in conflict with the Ethical and Religious Directives for Catholic Health Care Services. Any procedures or courses of treatment that do not comply with the Ethical and Religious Directives will be processed solely by Cigna Health and Life Insurance Company, under its exclusive authority and control.

The health care professionals and facilities that participate in these plan networks, including Seton and Providence, are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna Health and Life Insurance Company, Seton Insurance Company, or their affiliates.

All group health insurance policies and group benefit plans contain exclusions and limitations. ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE POLICIES PAY LIMITED ACCIDENT-ONLY BENEFITS. For costs and complete details of coverage, contact the insurer.

Performance plans are considered Exclusive Provider plans and Performance Plus plans are considered Preferred Provider plans with certain managed care features. Cigna Health and Life Insurance Company (CHLIC) insures the reproductive health benefits under these plans, with medical benefits administered by QualCare, Inc. (a Cigna company) and pharmacy benefits administered by CHLIC. Out-of-area plan benefits are insured or administered by Cigna Health and Life Insurance Company, with certain administrative services provided by QualCare, Inc. Cigna Dental Choice and Dental PPO plans are insured and administered by CHLIC, respectively, with network administration services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. Cigna Dental HMO plans are insured by Cigna Dental Health of Texas, Inc. Cigna Vision plans are insured or administered by CHLIC. Term life, accident, and disability plans are insured or administered by Life Insurance Company of North America. Group Universal Life insurance policies are underwritten by Connecticut General Life Insurance Company.

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