WINTER 2019

NETWORK INSIDER

Cigna-HealthSpring news you can use

ON-DEMAND WEBINAR TRAINING

Clinical documentation series

The clinical documentation on-demand webinar training series is here. Each course listed below has been approved for 0.25 hours of PRA – category one Continuing Medical Education (CME) units:

- Heart failure
- Peripheral arterial disease
- Hypertension
- Osteoporosis
- Cerebral vascular accidents
- Chronic pulmonary disease

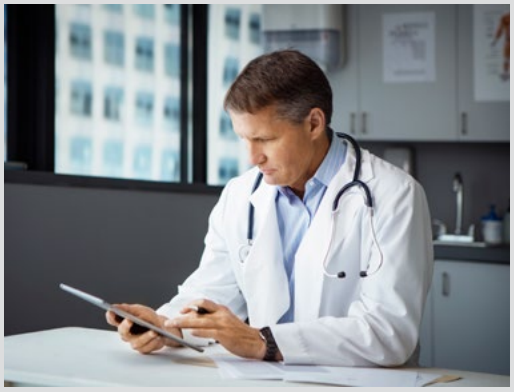
PART D PRIOR AUTHORIZATIONS MADE EASIER

New, online process now available

Cigna-HealthSpring has teamed with CoverMyMeds® to help prescribers and pharmacies:

- Submit and track PAs online.
- Ensure all required information is submitted.
- Reduce paperwork related to missing information.
- Receive electronic determinations.
- Create renewals from previous requests.

It's free and HIPAA-compliant. Sign up at www.CoverMyMeds.com.



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Cigna HealthSpring® CarePlan

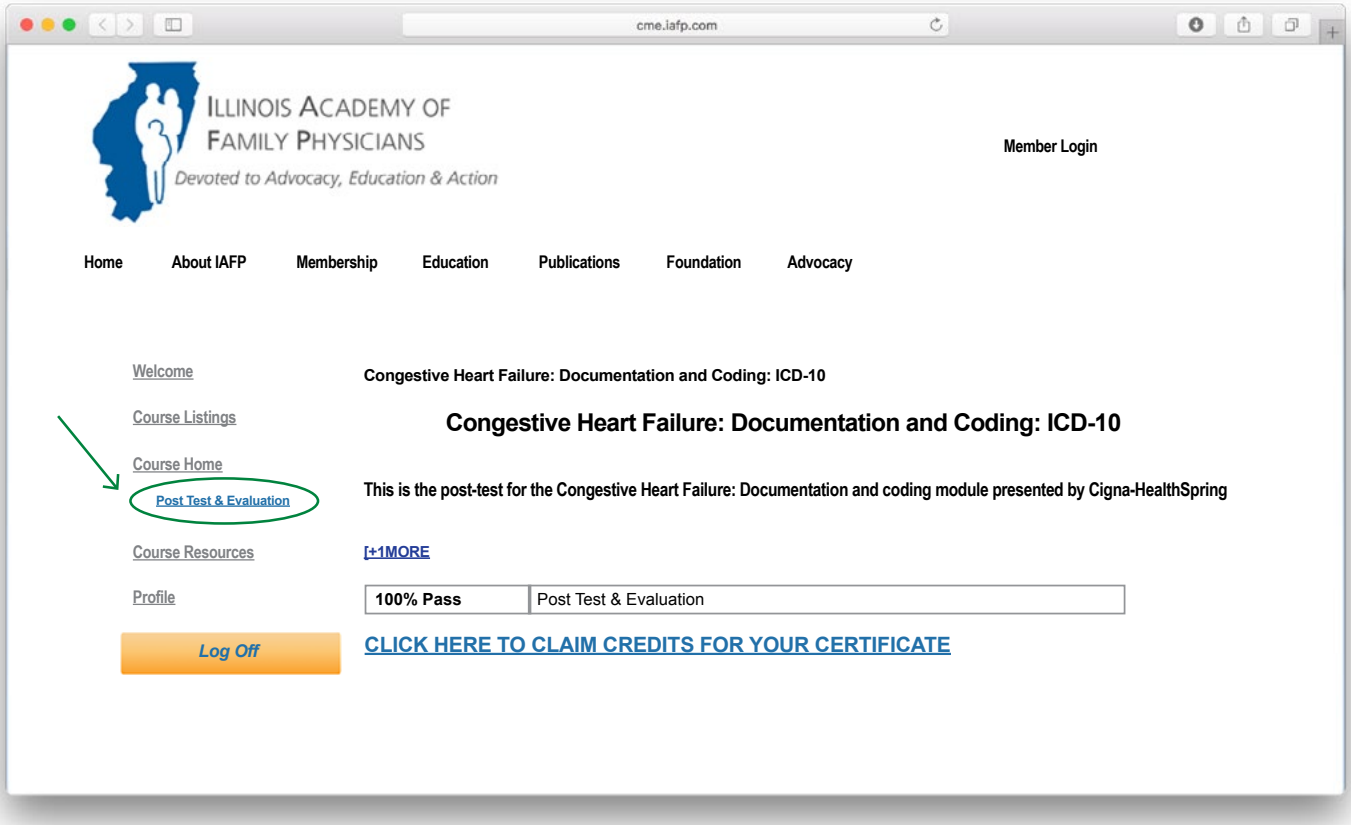
TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

ON-DEMAND WEBINAR TRAINING *(CONTINUED)*

Please pass this information on to our partnering clinicians. CME is not required, but may be deemed as a value opportunity for clinicians that care for our membership. Instructions for attainment of CME are as follows.

1. First, the attendee will link to the content by clicking the specific topical Internet hyperlink above.
   - Prior to content launch the attendee will be prompted to provide demographic information
   - Of note – When viewing this content, mobile devices are not supported, therefore the content can only be viewed using a desktop computer with one of the following browsers: Safari, Internet Explorer, or Google Chrome.
2. Second, after the content has been viewed the attendee will need to register or use their previously registered Illinois Academy of Family Physicians (IAFP) account – this is a free online account.
3. Once logged on to the IAFP account the user will:
   - Migrate to the Post Test & Evaluation tab
   - Select one of the ICD-10 courses by clicking the specific topic
   - Select the Post Test & Evaluation link as noted in the picture below



CLINICAL SKINNY

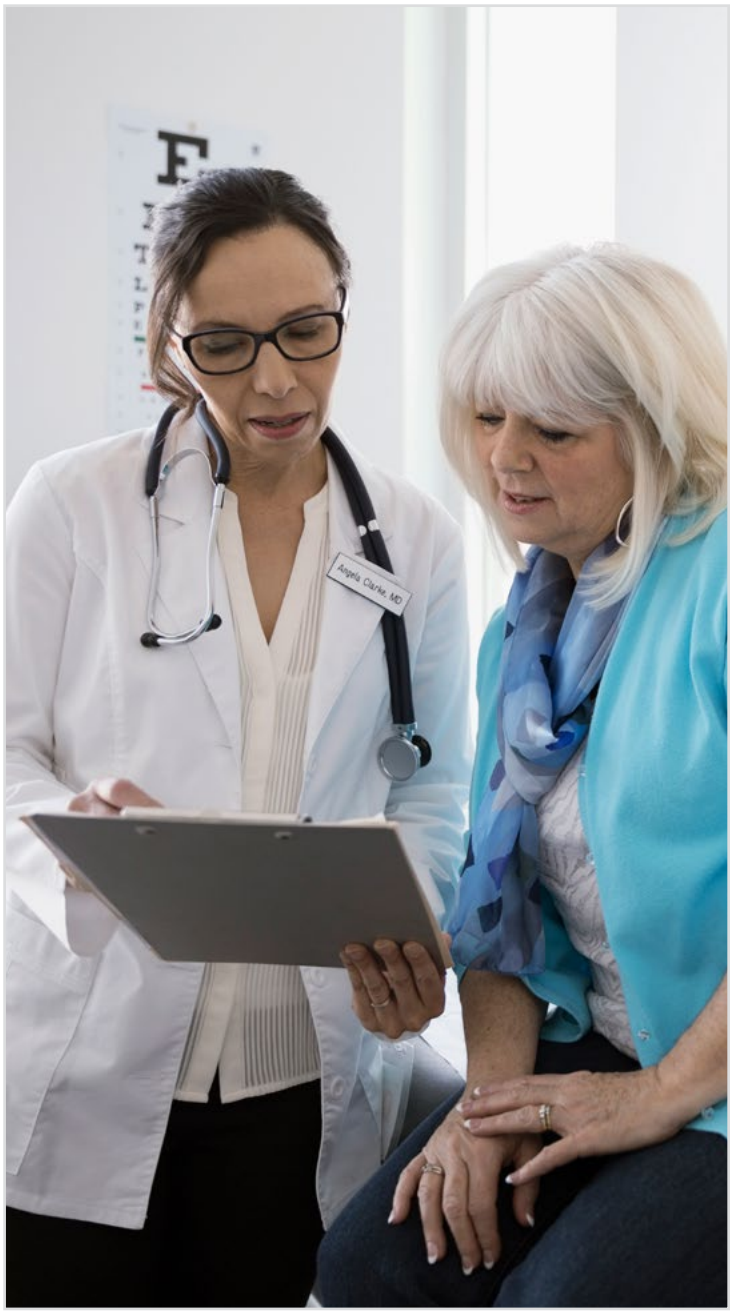
Linking Diabetes and Comorbid Manifestations

Diabetes is the seventh leading cause of death in the United States. This is related to the comorbid manifestations that commonly occur among diabetic patients. A good majority of these complications are associated with eye, kidney, and vascular complications.[1] These diabetic complications can cause blindness, kidney failure, and limb amputations if the diabetic condition is not aggressively treated.

Clinicians may or may not be aware that specific ICD-10 codes exist to illustrate the diabetes condition and comorbid manifestation(s). For example, ICD-10 code E11.22 describes type 2 diabetes mellitus with kidney complications. Diabetes and comorbid manifestations can be linked together using the words "with" or "in." Diseases that are linked together provide a more specific impact on the progression of illness severity. When clinically relevant, clinicians should be encouraged to link diabetes and comorbid manifestations together.

To help ensure providers are documenting to the highest degree of specificity for appropriate ICD-10 code assignment, please have clinicians visit the Cigna Coding and Documentation Education webpage.

- Providers must be diligent about confirming the accuracy of their diagnoses and ensure that their diagnosis and coding practices comply with all applicable legal requirements.
- Failure to address recurrent diagnosis inaccuracies can, in some cases, result in administrative sanctions and potential financial penalties.
- Accurate coding and submission activities allow us to provide the best benefits and resources possible to our customers.



References:

Centers for Disease Control and Prevention [CDC]. (2016). Diabetes: working to reverse an epidemic at a glance 2016 [webpage]. Retrieved from http://www.cdc.gov/chronicdisease/resources/publications/aag/diabetes.htm

2019 OPIOID CHANGES

The use of opioid medications presents serious risks, including addiction, overdose, and death. The Medicare population has among the highest and fastest-growing rates of opioid use disorder, with a current prevalence of six in every 1,000 beneficiaries.[1] New opioid initiatives for 2019 focus on strategies to help prevent and combat opioid overuse and abuse among the Medicare Part D population.

CMS will be requiring all Part D sponsors to implement safety controls at point-of-sale, including day supply limits on acute pain treatment in opioid-naïve patients, maximum daily morphine milligram equivalent (MME) limits with real-time care coordination, and precautions around concurrent therapy with benzodiazepines and duplicate therapy among long-acting opioids. Additionally, as part of the Comprehensive Addiction and Recovery Act of 2016 (CARA), Part D sponsors will be able to limit at risk beneficiaries' coverage for frequently abused drugs (opioids and benzodiazepines) to certain prescribers and pharmacies – often referred to as a "lock-in" program.

Please review the following upcoming opioid changes for 2019 and what you can do to ensure your patient receives his/her opioid therapy.

- Opioid prescriptions for the treatment of acute pain in opioid-naïve patients will be limited to a maximum of a seven-day supply.
  - Cigna-HealthSpring defines "opioid naïve" as patients who have not had an opioid medication filled within the past 120 days.
  - Prescriptions written for opioid-naïve patients for greater than a seven-day supply will be denied at point-of-sale and require a coverage determination.
- The maximum cumulative MME will be decreased to 90 mg/day. Opioid prescriptions for patients who exceed the 90 MME dose limit AND have two or more opioid prescribers will be denied at point-of-sale.
  - A coordination of care between the prescriber and dispensing pharmacist is encouraged. The dispensing pharmacist must consult with the prescriber and document the discussion. Upon receiving a confirmation of the prescriber's intent, the pharmacist may override the denial using pharmacy professional service (PPS) codes to receive a paid claim.
  - If the prescriber cannot be reached for consultation, the prescription will remain denied and may not be filled. If you're a prescriber and are prescribing an opioid medication to your patient, please be aware that the patient's pharmacy may need to consult with you prior to being able to dispense your patient's medication.

2019 OPIOID CHANGES *(CONTINUED)*

- Opioid prescriptions will be denied at point-of-sale if an interaction with a benzodiazepine is detected.
  - The dispensing pharmacist may override the denial with PPS codes if the pharmacist consults with the prescriber, provides patient counseling, and/or determines that it is safe to dispense the opioid medication.
- Opioid prescriptions for a long-acting opioid medication will be denied at point-of-sale if a duplication of therapy is detected between two or more long-acting opioid medications.
  - The dispensing pharmacist may override the denial with PPS codes if the pharmacist consults with the prescriber, provides patient counseling, and/or determines that it is safe to dispense the opioid medication.
- Drug Management Programs will utilize CMS-defined criteria to identify patients at risk for opioid overuse based on MME/day and using multiple prescribers and/or pharmacies to obtain opioids.
  - Cigna-HealthSpring will contact the prescribers of opioids for patients who are determined to be "at risk" in order to verify the appropriateness of the patient's opioid regimen. If you are contacted regarding your patient's opioid regimen, communication with the health plan is an important part of the process.
  - Based on prescriber consultation, the patient may be limited to receiving opioids from specific prescribers and/or pharmacies, or limited to a specific opioid medication regimen.
- Affected patients will be notified and offered the opportunity to submit their preferred prescriber and/or pharmacy in advance.

Important considerations to note

- Patients who are residents of a long-term care facility, in hospice or receiving palliative care, or being treated for active cancer-related pain are excluded from interventions described above.
- Patients' access to medication-assisted treatment (MAT), such as buprenorphine, is not impacted by the interventions described above.
- Patients and providers have the right to request a coverage determination.

For additional resources and information on Cigna's current opioid initiatives, visit Cigna.com/helpwithpain/

References:

1. Centers for Medicare & Medicaid Services (CMS) Opioid Misuse Strategy (2017 January 5), https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf
2. Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (2018 April 2), https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

STAR+PLUS MEDICAID RECERTIFICATION DATE

Enhanced Provider Portal Feature

In an effort to help ensure that Members do not lose eligibility, we have enhanced our provider portal to include the Members recertification date. https://starplus.hsconnectonline.com/login

This feature can be found on the Member Summary page, under the MESAVE tab.

NEW NURSING FACILITY CREDENTIALING REQUIREMENTS

All Medicaid MCOs are required to credential Nursing Facilities (NFs) contracted in their STAR+PLUS networks. The credentialing requirements were developed and defined by HHSC, and all Medicaid MCOs are required to use the same credentialing requirements.

The credentialing requirements were effective April 1, 2018, giving MCOs until June 30, 2019 to credential NFs within their STAR+PLUS networks. Per HHSC, MCOs are not allowed to contract with any NF that does not meet the credentialing requirements. Therefore, any NF that is not credentialed by June 30, 2019 will have their contract terminated. If an NF is not contracted and credentialed, the MCO may pay claims at 95% of the established contracted rate.

Credentialing for all five of the Medicaid MCOs is being directed through the Texas Association of Health Plans (TAHP) Certification Verification Organization (CVO). The CVO will reduce the administrative burden for the providers by being a single point of entry for credentialing with all five Medicaid MCOs. The CVO is managed by Aperture, a nationwide company specializing in credentialing health care providers.

Aperture has partnered with Availity to create an online portal for providers to complete the credentialing application, submit supporting documentation and track the status of their credentialing application. This one credentialing application and supporting documentation will then be shared with all five Medicaid MCOs. There is no charge for using Availity for credentialing.

The CVO will align all re-credentialing dates for all five Medicaid MCOs to be the same date, so future re-credentialing will be streamlined as well.

If an NF is NOT already credentialed, you can go to the Availity website to start the credentialing process: www.Availity.com

Refer to the link below for more information on the CVO and the credentialing application process: http://connect.tahp.org/news/379282/CVO-Implementation-Updates.htm or Cigna-HealthSpring's website at: https://www.cigna.com/starplus/health-care-professionals/pharmacy-nursing/nursing-facility.

ELECTRONIC VISIT VERIFICATION (EVV) FAILED TO EXPORT REPORT PROCESS

All agencies that provide the following services must use the EVV system and must complete all required visit maintenance in the EVV system within 60 days of the first date of service.

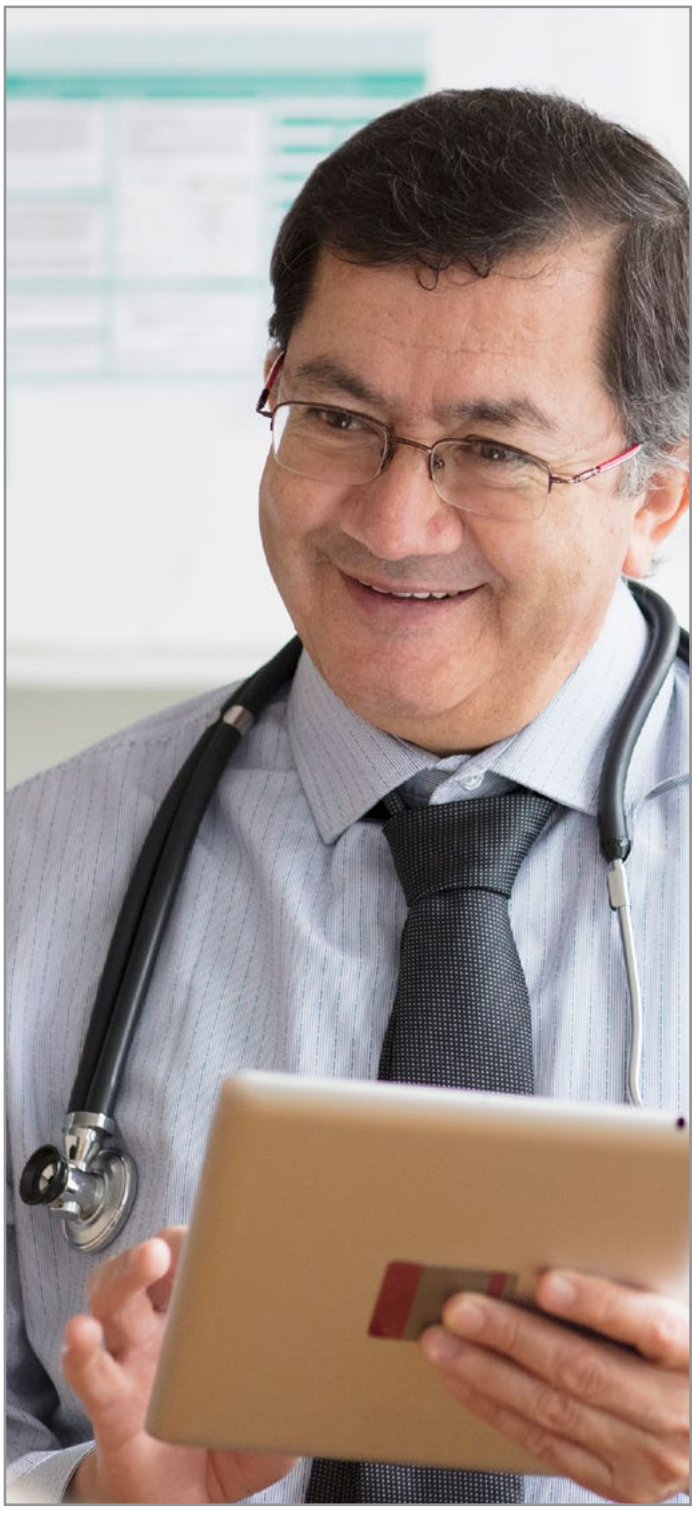
- Personal Assistance Services (PAS)
- Personal Care Services (PCS)
- Community First Choice (CFC) – PAS and Habilitation (HAB)
- In-home respite

Prior to submitting a claim to Cigna-HealthSpring, providers must review DataLogic's (Vesta) Failed to Export Report to identify if there are any unsent transactions or transactions that have been rejected by CHS.

Reminders:

- If the report shows unsent or rejected transactions, the provider must make the applicable corrections to ensure all data elements are correct and the transaction(s) is submitted to the correct payer.
- Please keep in mind that transactions can be rejected for multiple reasons.
- Before billing CHS, please verify and confirm all transactions associated with the claim have been successfully transmitted to CHS.
- Failure to review the Failed to Export Report and make applicable corrections prior to submitting a claim to CHS may result in your claim being denied or recouped. For training on how to use the Failed to Export Report, please contact Vesta at 1-844-880-2400 or email them at info@vestaevv.com

For additional questions, contact our Provider Services Department at 1-877-653-0331.

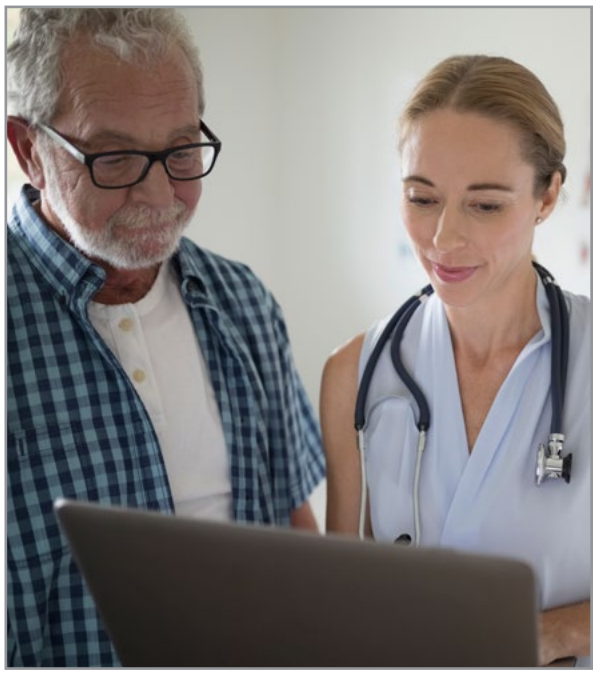


DIABETES SCREENING FOR PEOPLE WITH SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING ANTIPSYCHOTICS (SSDs)

Research shows that diabetes screening rates are low among adults with severe mental illness such as schizophrenia or bipolar disorder. In the November 9, 2015 online edition of JAMA Internal Medicine, researchers reported that less than one-third of mental health patients were screened for type 2 diabetes, despite an elevated risk for the disorder. It was also noted that treatment with antipsychotic drugs contributed to the risk for diabetes. The American Diabetes Association recommends that anyone taking these drugs should undergo diabetes screening every year. Yearly screening leads to early identification and treatment of diabetes. The absence of appropriate diabetes screening for people with schizophrenia or bipolar disorder using antipsychotic medications can lead to worsening health and death.

Tips for HEDIS Improvement

- Do not rely on the patient to follow through with scheduling recommended future appointments. Encourage office staff to schedule follow-up appointments.
- Routinely arrange lab appointments when the patient is in the office.
- Confirm that the billing code related to the selected service is a HEDIS-appropriate code. The codes to identify diabetes screening are as follows: CPT for glucose test- 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 CPT for HbA1c- 83036, 83037 CPT II- 3044-3046F
- Ensure accurate documentation and timely submission of the test.
- Ensure that patients who do not have regular contact with their PCP but regularly see the Behavioral Health provider get diabetic lab tests done.
- Ensure that patients and caregivers are aware of the risk of diabetes, and understand the symptoms of new onset diabetes while taking antipsychotic medication.
- Educate patients and caregivers about local community support resources.



References:

https://www.webmd.com/diabetes/news/20151111/too-few-psychiatric-patients-screened-for-diabetes-study

http://clinical.diabetesjournals.org/content/24/1/18

http://www.diabetes.org/newsroom/press-releases/2018/expanded-access-to-prevention-programs-and-acknowledging-increased.html

CUSTOMER HOLD HARMLESS AND NON-COVERED SERVICE

Customer Hold Harmless

Participating providers are prohibited from balance billing Cigna-HealthSpring customers, including, but not limited to, situations involving non-payment by Cigna-HealthSpring, insolvency of Cigna-HealthSpring, or Cigna-HealthSpring's breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against customers or persons, other than Cigna-HealthSpring, acting on behalf of customers for Covered Services provided pursuant to the Participating Provider's Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances or deductibles for covered services in accordance with the terms of the applicable customer's Benefit Plan, or for collecting payment when rendering non-covered services if the provider complies with the requirements of the non-covered services section of the Provider Manual.

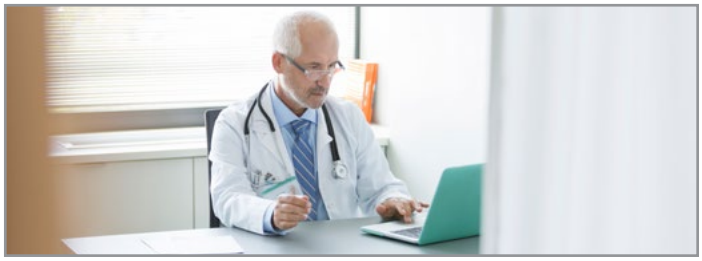
Non-covered Services

Providers may only collect fees from customers for non-covered services when the customer has been provided with a standardized written organization determination denial notice from Cigna-HealthSpring prior to the item or service being rendered to the customer, or if the customer's EOC clearly states the item or service is a non-covered service.

In circumstances where there is a question whether or not the plan will cover an item or service, customers have the right to request an organization determination prior to obtaining the service from the provider. If coverage is denied, Cigna-HealthSpring provides the customer with a standardized written organization determination denial notice which states the specific reasons for the denial and informs the customer of his or her appeal rights. In absence of the appropriate Cigna-HealthSpring organization determination denial notice or a clear exclusion in the EOC, the customer must be held harmless (i.e., cannot be held financially liable for the charges).

When a provider knows or believes that a service or item is not covered under the customer's benefit, and the EOC does not explicitly state the item or service as non-covered, the provider must advise the customer to request a pre-service organization determination from Cigna-HealthSpring or the provider can request the organization determination on the customer's behalf before the provider moves forward with rendering the services, providing the item, or referring the customer to another provider for the non-covered item or service.

Providers may not issue any form or notice that advises the customer they will be responsible for the costs associated with non-covered services unless the customer has already received the appropriate pre-service organization determination denial notice from Cigna-HealthSpring or the service or item is explicitly stated as a non-covered service in the EOC.



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