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Help your patients save the date

Medicare Annual Enrollment begins October 15th and ends December 7th.

For more information, call Cigna-HealthSpring® at 1-800-668-3813 (TTY 711) 7 days a week, 8 a.m. – 8 p.m. or visit CignaHealthSpring.com.

Call your network operation representative today to create a specific marketing plan for your practice!

Quality improvement program – Drive to Five Stars

Cigna-HealthSpring maintains a comprehensive, systematic, and continuous quality improvement program. The scope of the program includes all health care and administrative services provided to all Cigna-HealthSpring members in all geographic areas. Our internal oversight department monitors a spectrum of measures that assess and evaluate the quality of care and services provided by Cigna-HealthSpring. Each of these quality improvement activities is described, trended, and analyzed in an evaluation of the overall effectiveness of our Quality Improvement program.
Local coverage determinations

Cigna-HealthSpring abides by Center of Medicare and Medicaid Services (CMS) payment policies, and National Coverage Determinations (NCDs).

In the absence of an NCD, Cigna-HealthSpring utilizes applicable Local Coverage Determinations (LCDs). LCDs are specific written policies made by the Medicare Administrative Contractor (MAC) with jurisdiction for each individual State.

However, alternate LCD's for other MAC's will be considered if there is no LCD for the service identified by one of our intermediaries.

Cigna-HealthSpring uses the following hierarchy of references/resources:

1. National Coverage Determination (NCD) or other Medicare guidance, e.g. Medicare Policy Benefit Manual, Medicare Managed Care Manual, Medicare Claims Processing Manual, Medicare Learning Network (MLN) Matters Articles
2. Local Coverage Determination (LCD) or Local Policy Articles (A/B MAC & DME MAC)
3. Cigna-HealthSpring Medical Policies/ Coverage Determination Guidelines

CMS-1500 claim form implementation

The National Uniform Claim Committee (NUCC) has published the new version of the CMS-1500 form. The revised form is designed to align the 1500 with necessary changes to accommodate reporting needs for ICD-10. The final rule has mandated the use of the new CMS-1500 Claim Form effective 04/01/2014.

Cigna-HealthSpring began accepting the new form on 04/01/2014. Both forms will be accepted until 10/01/2014, at which time only the new version will be accepted per CMS Guidelines.

Clinical focus – malnutrition and obesity

Malnutrition

Malnutrition prevalence estimates vary considerably by setting/patient population. In a retrospective analysis of over 4,500 geriatric patients with mean age of 82.3 years from 12 countries the overall prevalence of malnutrition was 22.8% (Kaiser M, Bauer J, Rämsch C, et al., 2010). Table 1 describes malnutrition prevalence by setting (Kaiser M, Bauer J, Rämsch C, et al., 2010).

Table 1: Prevalence of malnutrition in geriatric population by setting

<table>
<thead>
<tr>
<th>Clinical Setting</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation</td>
<td>50.5%</td>
</tr>
<tr>
<td>Hospital</td>
<td>38.7%</td>
</tr>
<tr>
<td>Nursing home</td>
<td>13.8%</td>
</tr>
<tr>
<td>Community</td>
<td>5.8%</td>
</tr>
</tbody>
</table>

The 2012 Consensus statement from the Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition recommends patients exhibit at least two of the following characteristics to document malnutrition (White JV, Guenter P, Jensen G, et al., 2012):

- Insufficient energy intake
- Weight loss
- Loss of muscle mass
- Loss of subcutaneous fat
- Localized or general fluid accumulation that may mask weight loss
- Diminished functional status – reduced hand grip

The Mini-Nutritional Assessment (MNA) is a common measure used with the geriatric population to screen for and document malnutrition. The 6 question measure is administered by a clinician and takes approximately 5 minutes to complete. The measure developer, Nestle, recommends screening community dwelling patients yearly and patients at increased risk for malnutrition (e.g., hospitalized, change in condition) up to every 3 months. If the patient cannot answer questions then a caregiver familiar with the patient is an acceptable informant. The MNA form and various translations, mobile device apps, instructions for incorporation in electronic medical records, and clinician instructions are found at http://www.mna-elderly.com.

Additional clinical documentation to support the diagnosis of malnutrition could include body weight less than 80% of recommended weight, significant weight loss from baseline, and prealbumin <15.0 mg/L (Ritchie C, 2013, Beck F & Rosenthal T, 2002)
Obesity

The estimated prevalence of obesity in adults > 65 years old is 35% (Fakhouri T, Ogden C, Carroll M, et al., 2012).

The clinical documentation needed to support an obesity diagnosis includes BMI, changes in weight, dietary intake (food variety, caloric intake and appetite), physical activities, social history, comorbid conditions and current medications (e.g., insulin, sulfonlureas, thiazolidinediones and antipsychotics).

Table 2 describes the classifications of obesity.

Table 2: Obesity classification

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI (kg/m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight</td>
<td>≥25.0 to 29.9</td>
</tr>
<tr>
<td>Obesity – Class I</td>
<td>30.0 to 34.9</td>
</tr>
<tr>
<td>Obesity – Class II</td>
<td>35.0 to 39.9</td>
</tr>
<tr>
<td>Obesity – Class III</td>
<td>≥40</td>
</tr>
</tbody>
</table>

Key clinical documentation features for malnutrition and obesity

After documenting the clinical findings (including BMI), clinicians need to state the diagnosis and indicate severity if applicable.

For example, the clinician can document “moderate malnutrition”; “protein calorie malnutrition” or “morbid obesity”.

Generally, clinician judgment is required to differentiate between moderate and mild malnutrition. Clinicians can consider biochemical changes in electrolytes, lipids and blood plasma.

Key coding issues for malnutrition and obesity

Coding Tip – Generally two diagnostic codes are identified. First is based on clinician diagnosis and the second is based on BMI.

Tables 3 and 4 outline the diagnostic codes associated with malnutrition and obesity respectively.

Table 3: Diagnostic codes associated with malnutrition

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>262</td>
<td>Other severe malnutrition</td>
</tr>
<tr>
<td>263</td>
<td>Other and unspecified protein-calorie malnutrition (nutritional dwarfism, physical retardation)</td>
</tr>
<tr>
<td>263.0</td>
<td>Malnutrition moderate degree</td>
</tr>
<tr>
<td>263.1</td>
<td>Malnutrition mild degree</td>
</tr>
<tr>
<td>263.2</td>
<td>Arrested development following protein-calorie malnutrition</td>
</tr>
<tr>
<td>263.8</td>
<td>Other protein-calorie malnutrition</td>
</tr>
<tr>
<td>263.9</td>
<td>Unspecified protein-calorie malnutrition</td>
</tr>
<tr>
<td>799.4</td>
<td>Cachexia (Tip: Assign additional code for associated malnutrition)</td>
</tr>
</tbody>
</table>

Kwashiorkor (260) and nutritional marasmus (261) are extreme forms of malnutrition and associated with children and developing countries.

Table 4: Diagnostic codes associated with obesity

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>278.00</td>
<td>Obesity, unspecified (BMI = 30-39.9)</td>
</tr>
<tr>
<td>278.01</td>
<td>Morbid obesity (BMI &gt; 40)</td>
</tr>
<tr>
<td>278.02</td>
<td>Over weight (BMI = 25-29.9)</td>
</tr>
<tr>
<td>278.03</td>
<td>Obesity hypoventilation syndrome (Pickwickian syndrome)</td>
</tr>
</tbody>
</table>

The final diagnostic codes associated with malnutrition are status or “V codes” for patients’ BMIs. BMIs can be drawn from nurses or dietitians’ notes. The examining clinician must interpret all of the clinical findings and provide a clinical diagnosis or impression.

References


2014 ERA/EFT enrollment process

Electronic Remittance Advice (ERA) and Electronic Fund Transfer (EFT) Now Available!

As changing market dynamics continue to increase the pressure to maximize revenue and profit, providers and health care systems are searching for ways to reduce costs while increasing efficiency across the revenue cycle. To that end, we are pleased to announce that Cigna-HealthSpring® has partnered with Emdeon to deliver ePayment services, consisting of electronic remittance advice (ERA) transactions and electronic funds transfer (EFT) services.

You can now receive HIPAA-compliant 835 ERA files via the Emdeon Direct Connect clearinghouse channel, existing vendor channel, or Emdeon Payment Manager Deluxe. Providers who are able to automatically post 835 remittance data will save posting time and eliminate keying errors by taking advantage of 835 ERA file service.

EFT is an electronic payment method (versus paper check) that directly deposits funds, which can improve and transform your reimbursement process. It allows for faster reimbursement, payments are distributed more securely by virtually eliminating lost check payments, and cash flow is accelerated.

If you sign up for EFT, you will automatically be enrolled to receive ERA as well.

Please see the following instructions if you would like to enroll for ERAs or EFT.

RA enrollment process

- Download Emdeon Provider ERA Enrollment Form at the following location: http://www.emdeon.com/resourcepdfs/ERAPSF.pdf
- Complete and submit ERA Enrollment Form via Email or Fax to Emdeon ERA Group:
  - Email: batchenrollment@emdeon.com
  - Fax: 1-615-885-3713
- Any questions related to ERA Enrollment or the ERA process in general, please call Emdeon ePayment Solutions at 1-866-506-2830 for assistance.

NOTE: ERA enrollment for all Cigna-HealthSpring health plans must be enrolled under Cigna-HealthSpring Payer ID “52192”.

EFT enrollment process

If you are already enrolled with Emdeon for EFT:
- Complete the EFT payer add change delete authorization form at http://www.emdeon.com/epayment/enrollment/EFTPCF.php
- Under the change/add/delete section, the first two columns use the Cigna-HealthSpring information (52192 and Cigna-HealthSpring)
- The last two columns will be your information
- The document can be submitted electronically with eSign located at bottom of form window.

If you are not enrolled with Emdeon for EFT, there are two methods to enroll for EFT:
- Emdeon ePayment Enrollment Form: http://www.emdeon.com/epayment/enrollment/enrollform.php
- Emdeon ePayment Enrollment Wizard Online: http://www.emdeon.com/eft/index.php

Any questions related to EFT and/or ERA Enrollment or the EFT and ERA process in general, please call Emdeon ePaymentSolutions at 1-866-506-2830 for assistance.
Fraud, waste, and abuse

Cigna-HealthSpring has policies and procedures to identify fraud, waste, and abuse in its network, as well as other processes to identify overpayments within its network to properly recover such overpayments.

These procedures allow us to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 C.F.R. § 422.503(b)(4)(vi) and 42 C.F.R. § 423.504(b)(4)(vi)(H), and Cigna-HealthSpring has policies and procedures in place for cooperating with CMS and law enforcement entities.

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

To report suspected or detected Medicare program non-compliance please contact Cigna-HealthSpring’s Compliance Department at:

Cigna-HealthSpring
Attn: Compliance Department
9009 Carothers Parkway, Suite B-100
Franklin, TN 37067

To report potential fraud, waste, or abuse please contact Cigna-HealthSpring’s Benefit Integrity Unit:

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

• **By phone:**
  1-800-230-6138
  Monday through Friday, 8:00 AM to 6:00 PM CST

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

Medicare made simple -
A brief guide to your health care options

If you have patients who have Medicare—or will soon be eligible for Medicare—it is important that they understand what is covered by the 3 basic plan choices. Your patients may need coverage beyond Original Medicare to meet their individual health care needs.

Patients with Medicare have 3 basic choices for health care coverage.

1. Rely on Original Medicare alone to provide coverage.
   It’s important to understand that Original Medicare alone covers only about 80% of most people’s medical expenses and does not provide prescription drug coverage. For Part D coverage, an additional stand-alone plan must be purchased.

2. Purchase a Medicare Supplement plan in addition to Original Medicare to fill the gaps not covered by Medicare alone.
   Medicare Supplement plans do not offer Medicare Part D prescription drug coverage. For Part D coverage, an additional stand-alone plan must be purchased.

3. Choose a Medicare Advantage plan that offers all the coverage of Original Medicare and many extra benefits, such as Part D prescription drug coverage, vision, dental, and more.
   Medicare Advantage plans provide these benefits through a contract with the government, so patients do not need to use their Medicare card to get medical services with this coverage.

Important information about Medicare Part D benefits

As of January 2006, Medicare-approved prescription drug coverage (Part D) went into effect. It gives people on Medicare the option to obtain Medicare-approved prescription drug coverage through healthcare plans offered by private companies. People can enroll in a plan that provides this Medicare-approved prescription drug benefit when they enroll in Original Medicare.

Long-term savings

Applying for a plan that provides Medicare-approved prescription drug coverage when a person is first eligible can help save thousands of dollars in the long term. It may also help save money by avoiding a government-imposed penalty for delayed enrollment that results in a higher premium for Part D coverage.

Medicare coverage options

One attractive plan option for people who become eligible for Medicare is a Medicare Advantage plan, which suits a variety of needs and budgets. Many people rely on these plans to help pay for some of the services NOT covered by Original Medicare. When choosing a plan, your patients should consider questions such as:

- How much can you afford?
- Do you want your plan to include prescription drug coverage?
- Which health care providers and pharmacies do you prefer to use?
- How much coverage do you want and need?

The advantages of Medicare advantage

Medicare Advantage Organizations have a contract with the federal government to provide all the coverage of Original Medicare, plus additional benefits and services—all in one simple plan. Many Medicare Advantage plans offer or include your Medicare Part D prescription drug coverage.

A person that joins a Medicare Advantage plan still has Medicare, but they do not need to show a Medicare card to get services.

Medicare Advantage plans will provide all Part A (hospital) and Part B (medical) coverage and other medically necessary services. Because much of the cost of these programs is provided through the government contract, premiums are generally lower than a Medicare Supplement plan or other private plan.

People who are about to become eligible for Medicare, may enroll in a Medicare Advantage and Part D prescription drug plan starting three months before the month of eligibility through three months following the month of eligibility. Otherwise they may need to wait for the next annual election period. These resources may also be helpful if your patients have questions or need more information:

Social Security Office:
1-800-772-1213 (TTY 1-800-325-0778)

Medicare Hotline and Website:
1-800-633-4227 (TTY 1-877-486-2048),
24 hours a day, 7 days a week
www.medicare.gov
Claims Mailing Address Change Notice

Recent Communication

In the most recent edition of Cigna Network News, dated July 2014, you may have noticed a change notification for claims sent to Kennett, MO.

These mailing address changes will not affect the Cigna-HealthSpring network. Please continue to send all paper claims, for Cigna-HealthSpring customers, to the El Paso, TX address. You may also submit claims electronically. ERA and EFT options are available as well, adding additional ease to the payment process. For all other Cigna business, refer to the Cigna Network News publication located here: http://editiondigital.net/publication/?i=217967

If you have questions about the claims address you should use, please call the Cigna-HealthSpring Provider Service Center at 1-800-230-6138.

Cigna-HealthSpring Claims Address

Mail Paper Claims to:
Cigna-HealthSpring
PO Box 981706
El Paso, TX 79998

Mail Appeals to:
Cigna-HealthSpring
PO Box 24087
Nashville, TN 37202

Mail Itemized Statements & Medical Records to:
Cigna-HealthSpring
PO Box 20002
Nashville, TN 37202

Electronic Payor ID: 52192
Electronic claims may be submitted through:
- Emdeon
- SSIGroup
- Availity
- Proxymed
- Medassets
- Zirmed
- OfficeAlly
- Relay Health
  (Payor ID: 1556)

Notes