WINTER 2017

NETWORK INSIDER

Cigna news you can use

HYPERTENSION:
Coding and documenting the diagnosis correctly

In 2016, the Centers for Disease Control (CDC) reported that 1 in 3 Americans have hypertension (HTN), and that nearly half of those that have the diagnosis are not well-controlled. The lack of blood pressure control contributes to co-morbid conditions such as diabetes and vascular disease, which unfortunately drives medical costs higher. Approximately $46 billion dollars of total health care costs were attributed to HTN. Identifying conditions like HTN and Diabetes Mellitus (DM) comprise the majority of this economic burden. Furthermore, the inflationary costs of these conditions can be associated with incorrect coding and documentation practices (Levinson, 2012). Therefore, clinicians must be responsible for confirming the accuracy of all chronic diseases in accordance with specific legal guidelines (Medicare Learning Network, 1997). Accurate coding and submission activities allow us to provide quality benefits and resources to the patients that are under your specific care. This article will briefly summarize the HTN diagnosis and provides coding and documentation guidance.

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The 360 Physical Exam. Why is it so important?
See page 2.

Inside

GETTING DRUGS APPROVED JUST GOT EASIER,
thanks to new forms available on our website.

Cigna.com/HealthSpringDrugForms

Save time. Get drugs approved faster. Receive less call backs. Benefit from newly redesigned forms.

Cigna®

MISDIRECTED CLAIMS

We strive for patient and provider-centricity every day. Misdirected claims have an adverse impact on both patients and providers. To learn more please visit:
CignaHealthSpring.com > Health Care Professionals > Misdirected Claims Information

THE 360 PHYSICAL EXAM

What is it and why is it so incredibly important to do it?

Your Cigna patients have received, or will soon receive, important information regarding the 360 Physical Exam and may want to discuss the benefits of the exam with you. The 360 is a deeper, more comprehensive physical exam, assessment and conversation enabler. It provides a full-circle picture of a patient's current health and risks to help improve overall health outcomes.

Please help us help you and your patients. Encourage the 360 physical exam. Thank you in advance.

	PRACTICE BENEFITS	PATIENT BENEFITS	WHAT'S INCLUDED
QUALITY CARE The 360 improves it.	• Meets quality metrics of current fee-for-value environment • Pays incentive for each completed 360 in addition to claim payment for G0438/G0439 • Improves compliance • Helps generate a customized care plan	• Added care with no added costs, fees or copays • Improves overall health outcomes • Increases satisfaction	• Medical history • Medication review • Past surgical history • Past family and social history • Physical exam • Review of systems • Pain screening • Depression screening • Fall risk screening • Diabetic foot exam • Preventive care • Health maintenance
PREVENTION The 360 focuses on it.	• Captures risk adjustment factor scores that affect reimbursements • Improves HEDIS scores • Creates pathway for recommending other Medicare-covered preventive services	• Helps detect many health problems while they are more treatable and less costly • Added benefits and services at no added cost	
TEAMWORK The 360 supports it.	• Helps team members access patient's current information and care plan • Improves overall coordination of care	• Team approach to care and services • Improves peace of mind	
RELATIONSHIP The 360 fosters it between you and your patients.	• Allows you to get to know your new and current patients better • Helps create a full-circle perspective on an individual patient	• Encourages conversation about health and life goals • Provides opportunity to discuss problems • Instills confidence	

For provider educational tools and resources regarding the 360 Physical exam, please visit: www.cigna.com/medicare/healthcare-professionals/icd-10

HYPERTENSION *continued*

In 2014, the Joint National Committee 8 (JNC-8) published guidelines to assist clinicians in caring for the HTN diagnosis (James, P. et al, 2014). Important disease definitions were developed to ensure the diagnosis of HTN is accurately made:

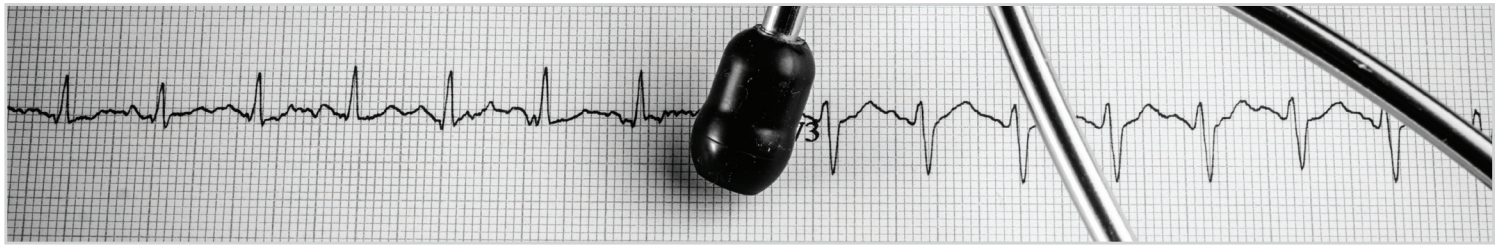
- HTN is diagnosed when the average of two or more (systolic of diastolic) blood pressure readings are found to be elevated on two or more office visits after an initial screen.
- It is important to note that Joint National Committee (JNC) 8 did not re-define high blood pressure, and the panel believes that a target of 140/90mmHg is an acceptable blood pressure threshold.
- Hypertension is no longer classified as being malignant, benign, or unspecified.
- Use of the I16.- codes (hypertensive urgency/emergency/crisis) should be documented when a patient has a systolic blood pressure of greater than 180mmHg or a diastolic blood pressure of greater than 110mmHg.
    - The hypertensive urgency (I16.0) code should be used when there is no presence of target organ damage,
    - The hypertensive emergency (I16.1) code should be used when there is presence of target organ damage.

Clinicians are trained to care for people and their illnesses. Unfortunately, coding and documentation skills are not typically taught to medical providers (Towers, 2013). Coding and documentation education seeks to bridge the learning gap that exists (Cusack, C et al., 2013 & Spellberg, B., 2013). Here are some coding and documentation tips that are aligned with the JNC-8 expert panel to improve your coding and documentation skill set for the diagnosis of HTN (James, P. et al, 2014):

- Explicitly document findings to support the diagnosis of HTN and the current manifestations when applicable. Secondary diagnoses that may be applicable include systolic/diastolic heart failure and/or chronic kidney disease,
    - Subjective considerations may be based upon the presence of risk factors alone when screening for HTN (United States Preventative Task Force - Evidence Level A, 2015). Risk factors for developing HTN include:
        - Advancing age,
        - African-American race,
        - Obese,
        - Sedentary lifestyle,
        - Diabetics,
        - Dyslipidemia,
        - Obstructive sleep apnea,
        - Tobacco and/or alcohol abuse,
        - High sodium diet – more than 3000mg daily,
        - Family history of HTN.

HYPERTENSION *continued*

- Objective considerations for the diagnosis of HTN include:
  - Prior to making the diagnosis of HTN confirmation can be obtained through ambulatory blood pressure monitoring,
  - When screening for a potential diagnosis of HTN the patient should not be acutely ill, and without hypertensive medications being on-board
  - Tips on measuring blood pressure:
    - Take the blood pressure when the patient has relaxed for 5 minutes,
    - Make sure that the blood pressure cuff is the appropriate size,
    - Avoid wrist blood pressure cuff measurements,
    - Measure blood pressure with both feet on the ground,
    - Take blood pressure in both arms,
    - Measure blood pressure after the patient has urinated.
  - Physical exam findings
    - Weight and body mass index (BMI)
    - Point of maximal intensity apical pulse shift away (typically laterally) from the mid-clavicular line suggestive of left ventricular hypertrophy
    - Fundoscopic exam suggests arterial-venous nicking, retinal hemorrhages and/or cotton-wool spots,
    - Distended neck veins,
    - Presence of vascular bruits,
    - Presence of a cardiac murmur, such as an S4.
  - Laboratory/imaging work-up:
    - Complete metabolic panel,
    - Fasting blood glucose,
    - Electrocardiogram,
    - Echocardiogram,
    - Fasting lipids,
    - Micro-albumin.
- There is no need to document multiple hypertensive codes sets, such as I10 (essential HTN), I11 (hypertensive heart disease), I12 (hypertensive chronic kidney disease), and I13 (hypertensive heart and chronic kidney disease). One code set that details the highest level of patient specificity is sufficient,
  - If chronic kidney disease (CKD) is linked to HTN, then clinicians need to document the stage of CKD using the (N18) code set,
  - If congestive heart failure is linked to congestive heart failure (CHF), then clinicians need to document the type of heart failure using the (I50) code set.



HYPERTENSION *continued*

- Document diagnostic statements that are compatible with the ICD-10 nomenclature,
- Confirm face-to-face encounter is signed and dated by clinician. Include printed version of clinician's full name and credentials (e.g., MD, DO, NP, PA),
- A chronic disease, like HTN, must have a valid treatment plan in order to be considered an active medical problem. Treatment plans can be in the form of a: medication, referral, diet, monitoring, and/or ordering a diagnostic exam. The goals of therapy are as follows:
- In persons over the age of 60 the blood pressure goal is suggested to be < 150/90mmHg,
  - For patients that are 60 years and older treatment should be started when systolic blood pressure (SBP) is ≥ 150mmHg or diastolic blood pressure (DBP) is ≥ 90mmHg,
  - In persons less than the age of 60 the blood pressure goal is suggested to be < 140/90,
  - For patients less than 60 years of age treatment should be started when DBP is ≥ 90mmHg,
  - Suggested JNC 8 treatment to consider include evidenced based treatments for selective populations:
    - African Americans with or without diabetes: Calcium channel blockers (CCB) and thiazide diuretics,
    - Non-African Americans: Angiotensin – converting enzymes (ACE), Angiotensin receptor blockers (ARB), thiazide diuretics and CCB,
    - Chronic kidney disease: ACE or ARB,
    - Heart failure: ACE or ARB,
    - Diabetics, non-African American: thiazide diuretics, CCB, ACE, or ARB should be considered,
  - Start one drug and titrate to maximum dose prior to adding a second drug,
  - Use the lowest dose possible to achieve the desired therapeutic effect,
  - Do not use an ACE and an ARB in combination on the same patient,
  - If blood pressure is not controlled after adding a third drug consider, referral to a hypertension specialist,
  - Be wary of orthostatic blood pressure occurrences in those that are elderly, as this may cause patients to fall,
  - Non-pharmacological considerations:
    - Diet,
    - Exercise,
    - Weight loss,
    - Salt restriction with a goal of less than 3000mg daily,
    - Encourage the patient to measure their blood pressure at home using an arm cuff.

HYPERTENSION *continued*

ICD-10-CM			
ICD-10-CM Code	**ICD-10-CM Description**	**Definition/Tip**	Additional tips
I11.0	Hypertensive heart disease w/heart failure	Use additional code to identify type of heart failure (I50.-)	Use additional code to identify: Exposure to environmental tobacco smoke (Z77.22) History of tobacco dependence (Z87.89) Occupational exposure to environmental tobacco smoke (Z57.31)
I11.9	Hypertensive heart disease w/o heart failure		
I12.0	Hypertensive chronic kidney disease (CKD) w/stage 5 CKD or endstage renal disease	Use additional code to identify the stage of CKD (N18.5, N18.6)	
I12.9	Hypertensive chronic kidney disease w/stage 1 through stage 4 CKD or unspecified CKD	Use additional code to identify the stage of CKD (N18.1-N18.4, N18.9)	
I13.0	Hypertensive heart and chronic kidney disease w/heart failure and stage 1 through stage 4 CKD or unspecified CKD	Use additional code to identify type of heart failure (I50.-) Use additional code to identify the stage of CKD (N18.1-N18.4, N18.9)	
I13.10	Hypertensive heart and chronic kidney disease w/o heart failure w/stage 1 through stage 4 CKD, or unspecified CKD	Use additional code to identify the stage of CKD (N18.1-N18.4, N18.9)	
I13.11	Hypertensive heart and chronic kidney disease w/o heart failure w/stage 5 CKD, or end stage renal disease	Use additional code to identify the stage of CKD (N18.5, N18.6)	
I13.2	Hypertensive heart and chronic kidney disease w/heart failure w/stage 5 CKD, or end stage renal disease	Use additional code to identify type of heart failure (I50.-) Use additional code to identify the stage of CKD (N18.5, N18.6)	

chart continued on next page

To help ensure you are documenting to the highest degree of specificity for appropriate ICD-10 code assignment, go to Cigna.com/CodingEducation.

HYPERTENSION *continued*

ICD-10-CM			
ICD-10-CM Code	**ICD-10-CM Description**	**Definition/Tip**	Additional tips
I15.0	Renovascular hypertension	Code also underlying condition	Use additional code to identify: Tobacco dependence (F17.-) Tobacco use (Z72.0)
I15.1	Hypertension secondary to other renal disorders		
I15.2	Hypertension secondary to endocrine disorders		
I15.8	Other secondary hypertension		
I15.9	Secondary hypertension, unspecified		
I16.0	Hypertensive urgency	Code also any identified hypertensive disease (I10-I15)	Use when SBP is ≥ 180mmHg or DBP is 110mmHg in the absence of associated organ damage
I16.1	Hypertensive emergency	Code also any identified hypertensive disease (I10-I15)	Use when SBP is ≥ 180mmHg or DBP is 110mmHg in the presence of associated organ damage
I16.9	Hypertensive crisis, unspecified	Code also any identified hypertensive disease (I10-I15)	A Life threatening rapid increase in the patient's blood pressure

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MEDICAL RECORD DOCUMENTATION STANDARDS FOR QUALITY ANNUAL AMBULATORY MEDICAL RECORD REVIEW

Definitions of Indicators: Adult Tool: The following standards and definitions of indicators correspond to the standards and numbered indicators on the Adult Medical Record Review Tool. Within those categories of standards are specific indicators or measures for compliance. **Reflecting national standards, these criteria are the minimum documentation requirements for quality care coordination, and do not include all required elements for the annual 360 examination.**

	STANDARD	DEFINITION
A	**Structural integrity and biographical data**	
1	All pages contain patient identification	One of the following will be recorded on each page of the record: Patient's full name and/or identification number (bar code or ID number)
2	Date of Birth	Actual month, day, and year the member was born must be documented in one of the following: › History and physical › Progress note › Face sheet
3	All entries dated	All entries must be dated.
4	All entries signed	Each entry must be signed by the provider or provider staff. All orders must be signed or cosigned by a physician. If initials are used in lieu of full signature, the office must keep on record a signature that is being abbreviated with any initials used. Electronic signatures must include authentication: e.g.: "Electronically signed," "Electronic Signature," etc.
5	Record is legible	The record is legible to the reviewer
B	**Health Assessment** (elements may come from visits on different dates, past 1-2 years)	
1	Advance Directive	There is documentation in the record that the issue of the living will or durable power of attorney has been addressed with the member.
2	Complete and current problem list	Significant illnesses and medical/psychological conditions are indicated on the problem list. Notations are dated. The problem list may be a separate document or included with each visit.
3	Medical and surgical history	Significant medical and surgical history is documented and updated every 1-2 years.
4	Physical Exam	Documented elements of a physical exam should include height, weight, and the patient's vital signs, along with elements of a cardiovascular, respiratory, gastrointestinal, and musculoskeletal exam at a minimum; exam should also include findings that correlate to presenting complaint or reason for visit.
5	Review of Systems	Documentation of review of at least 2-9 systems from constitutional, cardiovascular, genitourinary, psychiatric, hematologic/lymphatic, eyes, respiratory, integumentary, endocrine, ears/nose/throat, gastrointestinal, musculoskeletal, neurological, allergic/immunologic.
6	Presence or absence of allergies	NKDA or allergies and adverse reactions are boldly documented

MEDICAL RECORD DOCUMENTATION STANDARDS *continued*

	STANDARD	DEFINITION
7	Current medication(s)	
7.1	Name of medication	Prescribed medication(s) are documented.
7.2	Dosing information	Dosage is documented (how much, how often, and for how long).
7.3	Date of medication refill	Date of medication refill is documented.
8	Documentation for each encounter	
8.1	Reason for visit/chief complaint	The reason for each encounter is documented. May include the patient's own words .
8.1	Diagnosis/impression	The provider's diagnosis should relate to the presenting problem or complaint.
8.4	Plan of treatment	MD's plan of treatment is documented for each encounter: pertinent findings are addressed, including exacerbations for pre-existing conditions, medication(s), referral, diagnostic studies, etc. May also include instructions given to the patient.
8.5	Follow-up plan for each encounter	Specific time for follow-up visits or call should be documented in days, weeks, months, or PRN.
9	Continuity of care	
9.1	Consults, lab and test results reflect provider review	Evidenced by MD initials, electronic signature or notation in the record.
9.2	Follow-up for abnormal results	Consultation and abnormal lab and imaging results have explicit notation in the record reflecting follow-up.
9.3	Hospital discharge summaries in medical record	Hospital discharge summaries are included as a part of the medical record for all hospital admissions.
9.4	Patient noncompliance addressed by provider	Patient noncompliance is documented. Continued noncompliance is readdressed periodically.
C	**Counseling**	
1	Diet/exercise	Relative to fat, cholesterol intake, evaluation of lifestyle and calcium for females.
2	Substance use & abuse	Prevention and education relative to substance use is discussed (tobacco, alcohol, and other drugs).
3	Injury prevention	Use of seat belts, smoke detectors, and other injury prevention measures.
4	Sexual practices	Will focus on screening and education for patient and/or caregiver on individual risks (such as potential for abuse or STD risk, etc.) that may endanger health.

EASY STEPS TO ACCESS LIVE DISEASE-SPECIFIC WEBINARS

2017 calendar of disease-specific coding and documentation webinars

Free CME (for some topics) now available.

DATE	TIME CST	TOPIC
11/21/17	7:00 a.m.	Anticoagulation
11/21/17	11:30 a.m.	Anticoagulation
11/21/17	3:00 p.m.	Anticoagulation
12/19/17	7:00 a.m.	Obesity
12/19/17	11:30 a.m.	Obesity
12/19/17	3:00 p.m.	Obesity

FIGHTING THE OPIOID EPIDEMIC TOGETHER

Last year, we announced our commitment to help combat the nation's opioid epidemic. Since then, with the help of our health care provider partners, we've made significant progress toward reaching our goal to reduce opioid use among customers. Within the last 12 months, our customers' use of potentially hazardous opioids has declined nearly 12% – about halfway to achieving our goal of a 25% reduction by 2019. We have also made progress on improving the coordination of care of customers experiencing pain. We invite you to watch this video message from David Cordani, President & CEO, Cigna Corporation.

Cigna.Com/Medicare/HealthcareProfessionals/ch-newsletter/Fighting the Opioid Epidemic Together

To access the live disease-specific webinars please follow these three easy steps:

1. Click https://go.mc.iconf.net/fl/0oxz6bf
2. Set up the audio,
   a. Select "Dial-In Now" from the pop-up window that appears,
   b. Use your phone to dial **1-888-534-8066**,
   c. When prompted, dial the conference code: **3085470487**,
3. Click "Join Meeting" to access the presentation.

Instructions to obtain CME:

1. Launch the Cigna HealthSpring ICD-10 educational website, Cigna.com/CodingEducation
2. Select and view the on-demand educational program(s). The topics can be found in the disease specific training section of the Cigna HealthSpring ICD-10 website. The on-demand video will be launched from the Brainshark application/website,
3. After completing the on-demand voice over power point launch the Illinois Academy of Family Physicians (IAFP) website, http://cme.iafp.com/
4. If you do not have an IAFP continuing medical education (CME) account, then register for this cost-free account by clicking on the register link within the IAFP web site. Be sure to write down our user name and password for future reference,
5. After registering for the free account, go to the Post-Test and Evaluations tab,
6. Find the specific topic that corresponds with the course that you participated in or that you viewed,
7. After completing the post-test and the course evaluation you will be able to obtain your CME certificate, which may be printed or stored electronically.

UTILIZATION MANAGEMENT

Through our utilization management program, we help coordinate the care that your patients with Cigna Medicare Advantage coverage receive for certain services – such as diagnostic services, discharge planning, and the arrangement of home care services. Some of the ways we coordinate care is through prior authorization, precertification, and referral requirements. The goal is to help ensure our customers receive the clinically appropriate care, at the right time, that helps improve their quality and affordability of care.

Additional information

For more information about our utilization management program, please contact Cigna Medicare Advantage Customer Service at **1-800-627-7534**. To request prior authorization or precertification of services for your patients with Cigna Medicare Advantage coverage, call **1-800-558-4314**.

For information about precertification and other prior authorization processes, go to the Cigna for Health Care Professionals website: https://cignaforhcp.cigna.com.

Note: this website requires the user to login (a login can be created if the user does not already have one.) Once logged in, go to **Resources**, next go to **Medical Resources**, then go to **Doing Business with Cigna** and select **Precertification**.

URGENT CARE FOR NON-EMERGENCIES

People often visit emergency rooms for non-life-threatening situations, even though they usually pay more and wait longer. Why? Because they often don't know where else to go.

You can give your patients other options. Consider providing them with same-day appointments when it's an urgent problem. And when your office is closed, consider directing them to a participating urgent care center rather than the emergency room, when appropriate.

For a list of Cigna's participating urgent care centers, view our Provider Directory at https://providersearch.hsconnectonline.com/OnlineDirectory.

AMBULATORY MEDICAL RECORD REVIEW

Medical Record Standards

Annually, the Quality Department conducts an Ambulatory Medical Record Review to monitor compliance with national documentation standards for patient records. A random sample of physician records is selected for review. The records are scored using a tool that identifies 27 basic documentation elements taken from national standards. These elements are not an exhaustive list of requirements that satisfy the 360 Comprehensive Exam criteria.

Providers scoring less than 70% are asked if supplemental documentation is available to improve their score. If scoring remains less than 70%, additional patient records are requested for review. If the overall score still remains below 70%, providers are asked to work with the Senior Operations Director of Stars & Quality to implement an improvement plan. Cigna providers typically score well above 70% each year and we thank you for your commitment to continuity and coordination of care.

NETWORK INSIDER

Winter 2017

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