FALL 2018

NETWORK INSIDER

Cigna-HealthSpring news you can use

THE OPIOID EPIDEMIC

Information for prescribers

In 2015, opioids, including all prescription options and heroin, killed over 33,000 people — more than any previous year recorded.[1] It's been estimated that nearly half of all opioid overdose deaths involved a prescription.[1] As a result, providers are seeking alternatives to help address their patient's acute and chronic pain needs. So when should providers prescribe these "controversial" medications?

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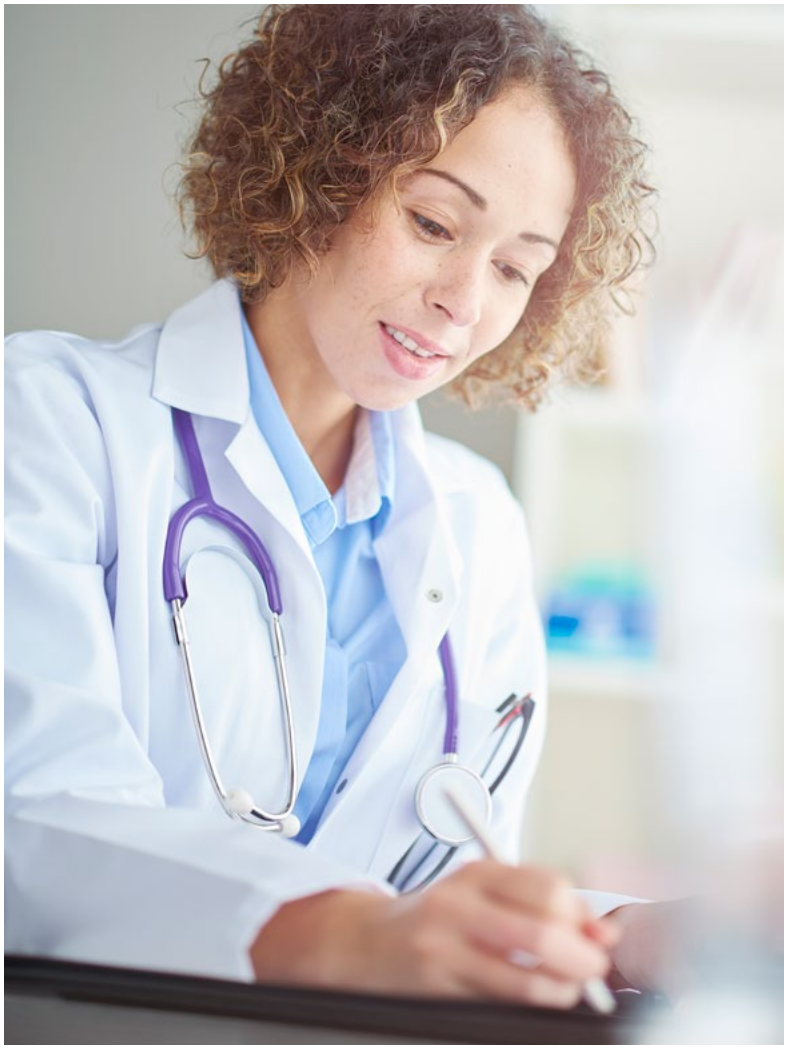

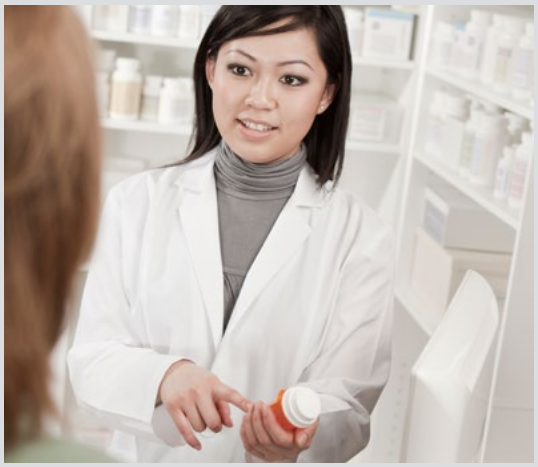

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THE OPIOID EPIDEMIC *continued*

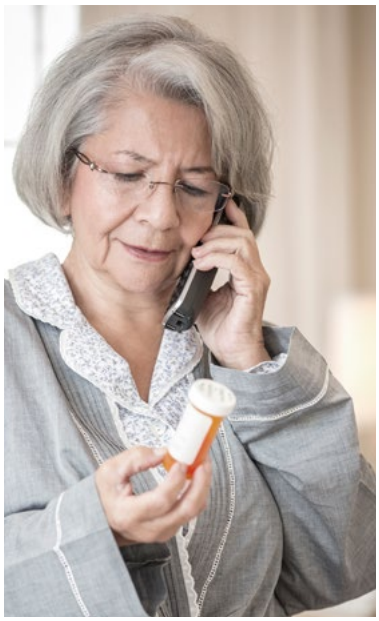
When should a prescriber consider prescribing opioids[2]?

Type of Therapy	Definition	Rationale for Opioid Prescribing	How to Initiate	Suggested Duration
Acute Pain Therapy	Pain lasting < 3 months.	Based on prescriber discretion, patient history, type and severity of pain.	Prescribers should initiate the lowest effective dose of immediate-release opioids for the shortest therapeutic duration of time.	Suggested duration of use is ≤ 3 days, but > 7 days is rarely needed.
Chronic Pain Therapy	Pain lasting > 3 months or past the time of normal tissue healing.	Primarily for active cancer, palliative and end-of-life care.	Before considering opioids for chronic pain, prescribers should determine how effectiveness will be evaluated and should establish treatment goals with patients.	Determined on a case-by-case basis.

Chronic pain considerations[2,3]

In general, it is not recommended to prescribe opioids as first-line treatment for chronic pain (> 3 months) for adults age 18 or older (excluding active cancer, palliative care or end-of-life care). However, there are times when opioids are the most appropriate choice for this subset of patients. Consider the following.

- Non-opioid pharmacologic and/or non-pharmacologic therapies are preferred in addressing chronic pain; however, prescribers should consider the utilization of opioids only if both the expected benefits for function and pain outweigh the risks to the patient. If a prescriber chooses to utilize an opioid, it should be combined with both non-opioid pharmacologic and/or non-pharmacologic therapies as appropriate to help the patient reach their therapeutic goals.



THE OPIOID EPIDEMIC *continued*

- Prior to initiating opioid therapy for chronic pain in a patient, prescribers must establish realistic treatment goals for pain and function. In addition, a discontinuation plan must be considered in the event that the benefits do not outweigh risks. Opioids should only be continued if there is clinical improvement in pain and function, and will not cause harm to the patient.
- Prior to initiating opioid therapy and also periodically during the course of therapy for chronic pain, prescribers should discuss the risks and realistic benefits of this therapy, and establish responsibilities between both the patient and prescriber to promote the best possible outcome.

Opioid dosing[2,4]

Higher opioid dosages have not been shown to reduce pain long term, yet, they are associated with a higher risk of overdose and death. When opioids are initiated, prescribers should prescribe the lowest effective dosage; in addition, immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids should be considered if initiating for chronic pain. Overall, caution should be used when prescribing opioids at ANY dosage. Prescribers should carefully reassess individual benefits and risks when looking to increase dosages to ≥50 morphine milligram equivalents (MME) per day, as well as avoid increasing/titrating a dosage to ≥90 MME/day unless there is ample justification. There are a number of online MME calculators to help calculate the total dosage of opioids.

Tapering opioids[5]

Care should be taken when tapering opioids to avoid withdrawal and/or unwanted physical sequelae. Turn to the next page for an excerpt from an article by Kral and colleagues, taken from Table 2, in "A Practical Guide to Tapering Opioids."

THE OPIOID EPIDEMIC *continued*

Suggested opioid-tapering guidelines[5]

American Academy of Pain Medicine (2009)	Veterans Affairs/ Department of Defense (2010)	Canadian National Opioid Use Guideline Group (2010)	ASIPP (2012) Agency Medical Directors Group (2010)
Slow • 10% reduction weekly **Rapid** • Rapid 25% to 50% reduction every few days • Anecdotal evidence of rapid tapering at oral morphine doses > 200 mg daily • Slow taper of oral morphine equivalent doses of 60 to 80 mg daily	**Variable** • Taper by 20% to 50% weekly • Slower tapering may be warranted **Rapid Tapers** • Decrease by 20% to 50% daily until 30 mg daily **Methadone** • Decrease to 30 mg daily • Then reduce by 5 mg daily every 3–5 days until 10 mg daily • Then reduce by 2.5 mg daily every 3–5 days until discontinued **Morphine** • Decrease to 45 mg daily • Then decrease by 15 mg daily every 2–5 days until discontinued **Oxycodone** • Decrease to 30 mg daily • Then reduce by 10 mg daily every 2–5 days until discontinued	**Slow** • Taper by 10% of the total daily dose every 1–2 weeks **Rapid** • Taper by 10% of the total daily dose every day • Once 1/3 of original dose is reached, reduce rate of taper by at least 50% • Consider switching patient to morphine if previously experienced addiction with hydromorphone or oxycodone. Use 50% of the calculated equianalgesic dosage to begin the tapering process	• Decrease by 10% of the original dose per week • Some patients may be weaned more rapidly over 6–8 weeks

References:

1. https://www.cdc.gov/drugoverdose/index.html
2. https://turnthetiderx.org/treatment/#
3. https://www.cdc.gov/drugoverdose/prescribing/guideline.html
4. https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf
5. Kral LA, Jackson K, Uritsky T. A practical guide to tapering opioids. Ment Health Clin [Internet]. 2015;5(3):102-8. DOI: 10.9740/mhc.2015.05.102.

IMPORTANT: The literature has not clearly outlined the best course for opioid tapers. As observed in the table above, dosage schedules and reductions are variable across each of the published guidelines referenced. Prescribers are encouraged to use their best judgment regarding which guideline to adhere to.

OBESITY

Obesity is a chronic disease with global epidemic prevalence, and clinicians are encouraged to screen patients on an annual basis.[1]

Facts

- Affects 35% of people age 65 and older.[2]
- Comorbid manifestations may include diabetes, cardiovascular disease and cancer.
- Linked to a reduction in life expectancy.
- Health care for obese people costs approximately $147 million dollars.[3]

Risk factors

- Sedentary lifestyle.
- Less than seven hours of sleep – leads to increased hunger.
- Preexisting physical or mental illnesses.
- Smoking cessation – can cause food intake to replace cigarettes.
- Low socioeconomic status – can lead to the cheaper, calorie-dense foods.
- Medication classes that include:
  - Antidepressants/epileptics/psychotics.
  - Beta-blockers.
  - Glucocorticoids.
  - Insulin.
  - Sulfonylureas.

Subjective questions

Like other chronic illnesses, the diagnosis of obesity needs to be supported through appropriate documentation. Clinicians should know the answer to questions such as:

- How long has the patient been obese?
- Has the patient undergone any treatment strategies to reduce their body weight?
- Are there any comorbid conditions that are related to being obese?

continued on next page

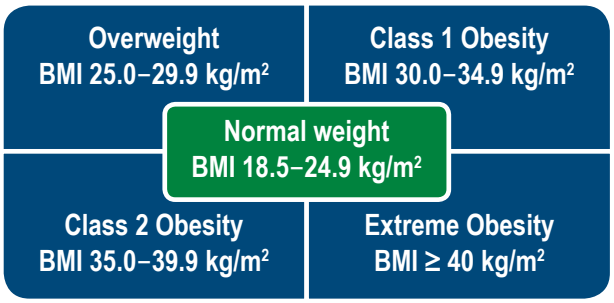
OBESITY *continued*

Objective measurements

The diagnosis of obesity is further supported by:

- Waist circumference.
- Body mass index (BMI).

The ICD-10 nomenclature utilizes the term morbid obesity and the NHLBI uses a classification method to define the severity of obesity. The National Health and Lung Blood Institute (NHLBI) transitioned away from the term morbid obesity and classified the disorder in the following stages.



Patients who have class 2 obesity are considered to be a higher mortality risk when they acquire the following conditions.[4]

- Coronary artery disease.
- Peripheral vascular disease.
- Abdominal aortic aneurysm.
- Carotid artery disease.
- Diabetes mellitus, Type 2.
- Sleep apnea.
- Hypertension.
- Hyperlipidemia.

Clinicians have the option of electively linking one of the comorbid manifestations above to the primary diagnosis of class 2 obesity by using the linking word "with" or "in" when the BMI is documented concurrently. For example, Obesity in a BMI of 37.0 kg/m² with diabetes mellitus type 2. Clinicians need to remember that a chronic disease needs to have at least one associated treatment plan, such as:

- Diet
- Referral
- Medication
- Monitoring and/or
- Diagnostic lab.

Documentation of BMI without clarifying the patient's nutritional status of obesity alongside the application of a specific treatment plan(s) is not acceptable. The ICD-10 codes below represent the BMI calculations (Z68.-) and for classifying obesity (E66.-).

ICD-10-CM code	ICD-10-CM description	Coding tip
E66.01	Morbid (severe) obesity due to excess calories	Use additional code to identify BMI, if known (Z68.-)
E66.1	Drug-induced obesity	
E66.2	Morbid (severe) obesity w/alveolar hypoventilation (Pickwickian syndrome)	
E66.3	Overweight	
E66.8	Other obesity	
E66.9	Obesity, not otherwise specified (NOS)	

OBESITY *continued*

ICD-10-CM code	ICD-10-CM description	ICD-10-CM code	ICD-10-CM description
Z68.25	Body Mass (BMI) 25.0–25.9, adult	Z68.35	Body Mass (BMI) 35–35.9, adult
Z68.26	Body Mass (BMI) 26–26.9, adult	Z68.36	Body Mass (BMI) 36–36.9, adult
Z68.27	Body Mass (BMI) 27.0–27.9, adult	Z68.37	Body Mass (BMI) 37–37.9, adult
Z68.28	Body Mass (BMI) 28–28.9, adult	Z68.38	Body Mass (BMI) 38–38.9, adult
Z68.29	Body Mass (BMI) 29–29.9, adult	Z68.39	Body Mass (BMI) 39–39.9, adult
Z68.30	Body Mass (BMI) 30.0-30.9, adult	Z68.41	Body Mass (BMI) 40.0–44.9, adult
Z68.31	Body Mass (BMI) 31–31.9, adult	Z68.42	Body Mass (BMI) 45–49.9, adult
Z68.32	Body Mass (BMI) 32.0–32.9, adult	Z68.43	Body Mass (BMI) 50.0–59.9, adult
Z68.33	Body Mass (BMI) 33–33.9, adult	Z68.44	Body Mass (BMI) 60–69.9, adult
Z68.34	Body Mass (BMI) 34–34.9, adult	Z68.45	Body Mass (BMI) 70 or greater, adult

References:

1. United States Preventive Services Task Force [USPSTF]. (2012, June). Obesity in adults: screening and management. Retrieved from [webpage] https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-adults-screening-and-management
2. Fakhouri, T., Ogden, C., Carroll, M., Kit, B., Flegal, K. (2012). Prevalence of obesity among older adults in United States 2007 to 2010. NCHS Data Brief 106. Accessed on 3/23/15 via weblink address http://www.cdc.gov/nchs/data/databriefs/db106.pdf
3. Flegal, K.M., Kit, B.K., Orpana, H., Graubard, B.I. (2013) *Association of all-cause mortality with overweight and obesity using standard body mass index categories: A systematic review and meta-analysis*. Journal of the American Medical Association, 309(1), 71–82.
4. Finkelstein, E. A., Trogdon, J. G., Cohen, J. W., & Dietz, W. (2009). *Annual medical spending attributable to obesity: payer- and service-specific estimates.* Health Affairs, 28 (5), w822–w831.
5. Jensen, et al. (2013). AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults. Journal of the American College of Cardiology, 63 (25 Part-B), 2985–3023. Retrieved from http://circ.ahajournals.org/content/circulationaha/early/2013/11/11/01.cir.0000437739.71477.ee.full.pdf
6. National Heart and Lung Blood Institute [NHLBI]. (2000). *NHLBI obesity education institute: the practical guide identification, evaluation, and treatment of overweight and obesity in adults.* Retrieved from https://www.nhlbi.nih.gov/files/docs/guidelines/prctgd_c.pdf

INTRODUCING NEW AVAILITY PORTAL

New, streamlined electronic credentialing

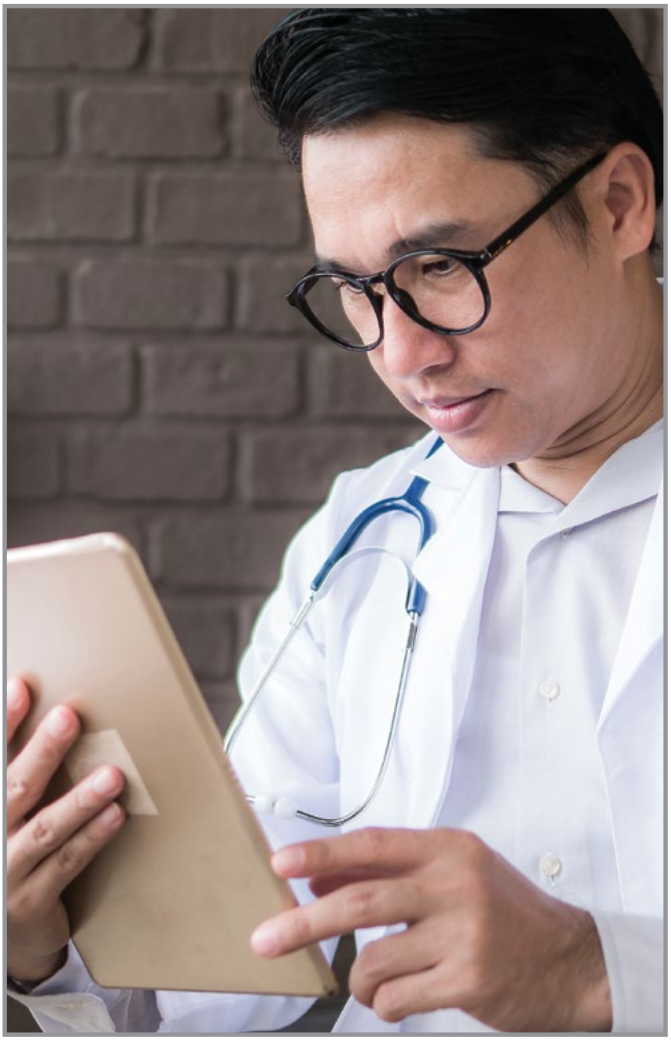
April, 2018 - The Texas Association of Health Plans (TAHP) and the Texas Medical Association (TMA), in collaboration with all HHSC-contracted Managed Care Organizations (MCOs), implemented a statewide Credentialing Verification Organization (CVO), managed by Aperture, to streamline the provider-credentialing process for Medicaid and CHIP providers.

As part of the effort, Aperture is pleased to announce that Availity, a credentialing application web portal, is now available to ancillary, facility and LTSS providers for electronic submission of application information.

Availity is free to providers, and a convenient, secure way to maintain credentialing information without having to constantly complete paper applications at initial or re-credentialing. All MCOs are converting to Availity for the submission of non-practitioner applications.

Please visit http://connect.tahp.org/news/379282/CVO-Implementation-Updates.htm to:

- Get an overview of Availity.
- Register to use Availity.
- Preview the credentialing application tool.
- Access the facility application and instructions.



To access the recorded training webinar and/or register to use the Availity system, you can:

1. Use your username and password to log in to the Availity portal: https://www.availity.com/ and click **Register** (in the upper right corner).
2. Click **Help & Training | Get Trained** in the top navigation bar. The Availity Learning Center (ALC) displays in a separate tab/window.
3. At the top of the ALC screen, search keyword “credentialing” and select course titled **“Credentialing on the Availity Portal – On-Demand.”**
4. Click **Enroll** at the top right of the description page.

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. 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-HealthSpring's participating urgent care centers, view our Provider Directory at http://starplussearch.mycignahealthspring.com/.

NEW CLARITHROMYCIN WARNING

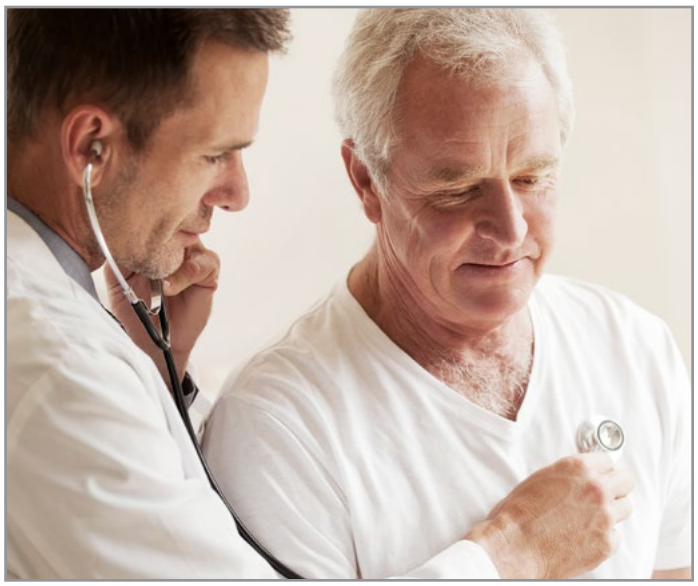
Potential for increased long-term risks in patients with heart disease

February 22, 2018 - The FDA released a drug safety communication cautioning use of clarithromycin in patients with heart disease.[1] This warning is based on a 10-year follow-up study of the CLARICOR trial, which demonstrated an unexpected increase in deaths among patients with coronary heart disease who received a two-week course of clarithromycin.

This increase in deaths became apparent after patients had been followed for one year or longer, and increased cardiovascular mortality was demonstrated for up to three years after clarithromycin administration.[2,3] These observations have warranted addition of a new warning about this increased risk of death in patients with heart disease, as well as addition of the study results to the clarithromycin drug labels.[1]

Macrolide antibiotics, such as clarithromycin, erythromycin and azithromycin, already carry warnings regarding QT prolongation and Torsades de pointes (TdP); however, these new warnings are unrelated to these established effects of QT prolongation and TdP. Researchers have no clear explanation of the mechanism leading to increased cardiovascular events and deaths after short courses of clarithromycin. There is currently no evidence to suggest that azithromycin or erythromycin increases long-term cardiovascular risk.[1,4]

The benefit of using clarithromycin in patients with heart disease should be weighed against the risks, and alternative antibiotics should be used, if possible. Patients taking clarithromycin should be made aware of signs and symptoms of worsening cardiovascular problems and advised to report these symptoms, if they were to develop. If clarithromycin is required



in a patient with coronary artery disease, prescribers should document the need for the medication and ensure the patient is prescribed other evidence-based therapies to reduce cardiovascular risk, such as HMG-CoA reductase inhibitor (statin) therapy. Clarithromycin and other macrolides should continue to be avoided, if possible, in patients with QT prolongation or taking other medications with QT-prolonging potential.[1,4]

1. Food and Drug Administration. FDA Drug Safety Communication: FDA review finds additional data supports the potential for increased long-term risks with antibiotic clarithromycin (Biaxin) in patients with heart disease. Available at: https://www.fda.gov/Drugs/DrugSafety/ucm597289.htm. Accessed on March 21, 2018.
2. Winkel P, Hilden J, Fischer Hansen J, et al., Clarithromycin for stable coronary heart disease increases all-cause and cardiovascular mortality and cerebrovascular morbidity over 10 years in the CLARICOR randomized, blinded clinical trial. International Journal of Cardiology 2015; 182:459–465.
3. Jespersen CM, Als-Nielsen B, Damgaard M, et al. Randomized placebo controlled multicenter trial to assess short term clarithromycin for patients with stable coronary heart disease: CLARICOR trial. BMJ 2006;332:22–7.
4. Article, *Manage New Warnings About Clarithromycin and Cardiovascular Risk*, Pharmacist's Letter, April 2018.

NEW FORMS FOR ELECTRONIC VISIT VERIFICATION

EVV Recoupment Reconsideration

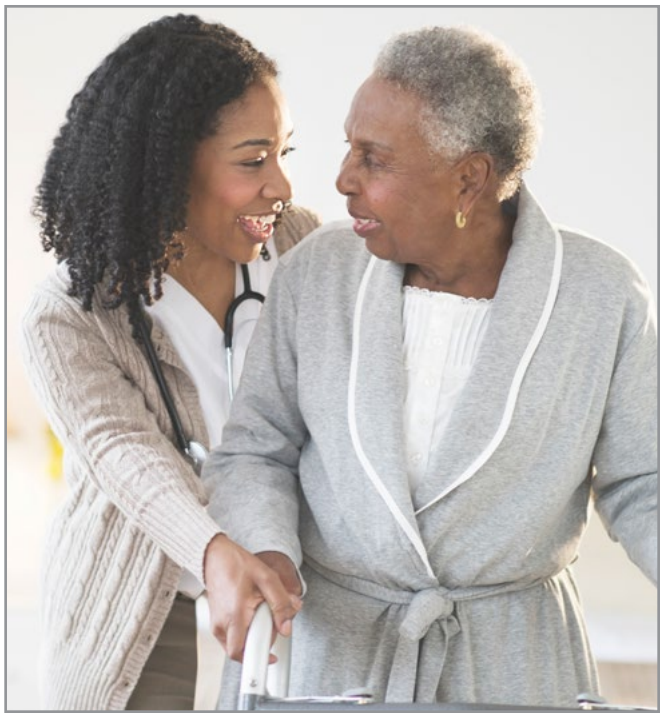
- EVV Review Request Form (Use only when you have verified visits to submit for reconsideration.)
- EVV Visit Maintenance Unlock Request Form (Use only for dates of services listed on your Request for Refund of Unverified Services letter – NOTE: Approval is at MCO's discretion.)

For forms regarding recoupment reconsiderations, visit https://www.cigna.com/starplus/health-care-professionals/provider-resources/forms

If you have questions, please call Cigna-HealthSpring STAR+PLUS Provider Services at **1-877-653-0331**.

HOME HEALTH SERVICES

New Type of Bill 321



Effective May 1, 2018 - The National Uniform Billing Committee has discontinued use of Type of Bill (TOB) 331 and re-designated TOB 321 as "Home Health (HH) Services under a *'Plan of Treatment-Admit through Discharge.'* "

Providers who are using TOB 331 on the UB04 claim form or electronic equivalent are now required to use TOB 321 instead. On the effective date, if TOB 321 is not filed appropriately for the type of service, claim will result in denial.

Please refer to the TMHP website, Section 6: Claims Filing, if you need additional direction.

WORKING TOGETHER WORKS

Update your provider information

It is important to keep our provider network information current. Up-to-date provider information allows us to accurately generate provider directories, process claims and communicate with our network of providers. Please inform us at least 30 days in advance when possible if any of the following changes:

- Practice ownership
- Federal tax ID number
- Practice name change
- Address, phone or fax numbers
- Office hours
- Office site location
- Providers joining or leaving the practice
- Primary care providers only:
  If your practice is open or closed to new patients

Changes should be submitted on the *Provider Change of Information Form* located on the Cigna-HealthSpring website at https://www.cigna.com/starplus/health-care-professionals/provider-resources/forms under the **Provider Forms** section.

How to contract with Cigna-HealthSpring

Important anti-discrimination notice

1. Any health care provider wishing to contract with Cigna-HealthSpring may submit an interest form located on the Cigna-HealthSpring website https://www.cigna.com/medicare/cigna-healthspring.

2. Cigna-HealthSpring reviews all interest forms and accepts or denies the request, based on a needs assessment related to the provider's specialty.

3. Should a provider be denied participation, a written notice is provided outlining the reasoning behind the denial.

IMPORTANT: No health care provider shall be discriminated against by Cigna-HealthSpring in reimbursement, participation or based on the population served.

Medical record documentation

Standards checklist

Let's work together to make sure your patient medical records include:

- ☐ Identifying patient information
- ☐ Identification of providers participating in care, and information on services furnished by these providers
- ☐ A problem list, including significant illnesses and medical and psychological conditions
- ☐ Presenting complaints, diagnoses and treatment plans
- ☐ Prescribed medications, including dosages and dates of initial or refill prescriptions
- ☐ Information on allergies and adverse reactions (or a note that patient has no known allergies or history of adverse reactions)
- ☐ Information on advanced directives
- ☐ Past medical history, including physical examinations, necessary treatments and risk factors relevant to the particular treatment

IMPORTANT: Cigna-HealthSpring may conduct site visits to determine whether the site conforms to the organization's standards for medical record keeping practices and confidentiality requirements.

PNEUMONIA VACCINATION FOR ADULTS AGE 65+

Recommendations timeline

2014 – The CDC issued an update on pneumococcal vaccination of adults age 65 and older in 2014. The recommendation was that adults 65+ be vaccinated with both Prevnar 13® (Pneumococcal 13-valent Conjugate Vaccine [Diphtheria CRM197 Protein])[1] and the Pneumovax 23 (Pneumococcal Polysaccharide vaccine 23 valent), based on the findings of the Advisory Committee on Immunization Practices (ACIP).[2]

Cigna-HealthSpring hospital admission statistics have shown pneumonia to be one of the top causes for admissions year over year. In an effort to address this serious health problem in the 65+ population, Cigna-HealthSpring supports the updated ACIP recommendations.

2016 – The CDC changed the recommendations for this population as follows:

Pneumococcal Vaccine-naïve* adults, age 65 and older	Adults previously vaccinated with PPSV23 at age 65 and older	Adults previously vaccinated with PPSV23 before age 65 who are now age 65 and older
Administer Prevnar 13 first	Administer Prevnar 13® *(at least one year after the most recent dose of PPSV23)*	Administer Prevnar 13® *(at least one year after the most recent dose of PPSV23)*
12 months later:† Administer dose of PPSV23‡ *(or during the next visit)*		12 months later,† administer subsequent dose of PPSV23‡ *(no sooner than five years after the most recent dose of PPSV23)*

Prevnar 13 is indicated for active immunization for the prevention of disease caused by Streptococcus pneumoniae serotypes 1,3,4,5,6A,6B,7F,9V,14,18C,19A, and 23F. Effectiveness of Prevnar 13 when administered less than five years after the PPSV vaccine is given are unknown.

Changes from the 2015 schedule included the following ACIP recommendations.

- Interval change for 13-valent pneumococcal conjugate vaccine (PCV13), followed by 23-valent pneumococcal polysaccharide vaccine (PPSV23) from "6 to 12 months" to "at least 1 year," for adults age 65+ who do not have immunocompromising conditions, anatomical or functional asplenia, cerebrospinal fluid leaks, or cochlear implants (1).
- The interval for adults age 19+ with any of these conditions is at least 8 weeks (2).[3]

Both pneumonia vaccines are a covered benefit for Cigna-HealthSpring customers

2018 - The ACIP will be reevaluating the recommendations for routine PCV13 use among adults aged ≥65 years and will revise as needed.

For more information, contact your Network Operations representative or go to:

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm

http://www.cdc.gov/mmwr/volumes/65/wr/mm6504a5.htm

References

* Pneumococcal vaccine naïve or unknown vaccine history.

† Minimum interval between sequential administration of Prevnar 13® and PPSV23 is 12 months; ‡The 2 vaccines (Prevnar 13® and PPSV23 should not be coadministered)

1 Prevnar 13® (Pneumococcal 13-valent Conjugate Vaccine [Diphtheria CRM197 Protein]) prescribing Information Wyeth Pharmaceuticals. Inc.; 2014=

2 Tomczyk S, Bennett NM, Stoecker C, et al; Centers for Disease Control and Prevention (CDC). Use of 13- valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine among adults aged ≥65 years: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Morb Mortal Wkly Rep. 2014; 63(37):822-825.3 http://www.cdc.gov/mmwr/volumes/65/wr/mm6504a5.htm

PROVIDER SATISFACTION SURVEY COMING THIS FALL

As with all relationships, it's important to take a moment to check in. Please take a moment (five minutes at most) to fill out the Provider Satisfaction Survey being sent out this fall. Your opinion is important and we value your feedback. You may complete this Survey on your own or share it with your nurse or office staff member. Once the survey is complete, please mail it to us in the envelope provided.

As always, thank you. If you have questions, please call Provider Services at **1-877-653-0331**.

NETWORK INSIDER

Fall 2018

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NETWORK INSIDER
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