FALL 2019

NETWORK INSIDER

Cigna Medicare Advantage news you can use

DIABETES PREVENTION PROGRAM

The Diabetes Prevention Program (DPP) offers a Medicare Diabetes Prevention Program (MDPP).

The MDPP is a structured intervention with the goal of preventing progression to type 2 diabetes in individuals with an indication of prediabetes. The MDPP helps participants learn to eat healthier resulting in weight loss, increase their activity, and make lifestyle changes to reduce their risk for type 2 diabetes. The primary goal is for participants to obtain at least a 5% weight loss.

The program benefit consists of a minimum of 16 "core" sessions over six months using the approved curriculum from the Centers for Disease Control and Prevention (CDC). The program is in a group-based, classroom-style setting allowing for enhanced interpersonal support and encouragement. MDPP also provides a lifestyle health coach to help set goals and keep participants on track. After completing the core sessions, monthly follow-up meetings help ensure that participants maintain healthy behaviors.

The MDPP also includes maintenance sessions for those who achieve the 5% weight loss goal and attend a minimum of two sessions per three-month period.

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Cigna®

DIABETES PREVENTION PROGRAM *CONTINUED*

Five eligibility requirements:

1. Enrolled in Medicare Part B
2. BMI of ≥ 25 (or ≥ 23, if self-identified as Asian)
3. No previous diagnosis of type 1 or type 2 diabetes (history of gestational diabetes will NOT impact eligibility)
4. No history of end-stage renal disease (ESRD)
5. In the past 12 months, one of these lab results:
   - A1C between 5.7-6.4%
   - Fasting plasma glucose 110-125 mg/dL
   - 2-hour plasma glucose 140-199 mg/dL (oral glucose tolerance test)

If eligible, MDPP is a covered preventive benefit available at no additional cost to the patient. This is a benefit that patients can participate only once in their lifetime.

Refer your eligible patients.

Cigna has partnered with Solera Health to provide the MDPP benefit. If you have an eligible patient, you may:

- Access the referral form at http://soleranetwork.com/medicaredpp.
- Send completed form to Solera via:
  - Fax **1-602-650-0690**, or
  - Email **screen@soleranetwork.com**.
- Questions? Call Solera Health at **1-877-486-0141**.

ANNOUNCING OUR NEW PROVIDER WEB PAGE

We are excited to introduce you to the new Arizona Medicare Advantage Provider web page URL designed specifically for our valued providers.

Be sure to bookmark the link below, in your web browser, for easy access to important information which will save you and your team time.

https://medicareproviders.cigna.com/az-region

What this means to you

Our provider webpage is a great resource for:

Eligibility & Claims Inquiry – Find a link to the Claimstat system to verify patient eligibility and to research your claims

Authorizations Forms – Quick access to forms like 360 exams, Population Health Management referral, Prior Authorization and more

Pharmacy – Find the current formulary as well as additional Pharmacy related information

You will also find these great educational resources:

- Quality
- Coding and Documentation
- 360 Exams

Questions or comments?

If you have anything you would like to share with us about your experience with our webpage, please contact your Network Operations Representative.

SAFETY UPDATES FOR OPIOID PAIN MEDICATIONS

Naloxone: When is Co-Prescribing Appropriate?

Despite efforts to reduce opioid abuse and misuse, opioid overdoses remain a significant concern in the United States. Combating the opioid epidemic requires a multimodal approach, including interventions targeted at preventing fatal opioid overdose events.

Important: Naloxone, an opioid antagonist, can swiftly and effectively reverse the effects of an opioid overdose. If administered in time, naloxone can save a life.

The United States Department of Health and Human Services (HHS) and Centers for Disease Control and Prevention (CDC) have released guidelines to encourage the use of co-prescribing naloxone with opioid prescriptions for patients at an increased risk of an opioid overdose. These guidelines recommend that clinicians should consider co-prescribing naloxone for patients who:

- Receive opioids at a dosage > 50 MME/day
- Have prescribed benzodiazepines
- Have diagnosed respiratory conditions (COPD or OSA), substance use disorder(s), or mental health conditions
- Report excessive alcohol use
- Have a history of overdose or opioid misuse
- Use illicit substances
- Receive treatment for opioid use disorder

Additional risk factors can be found at the CDC Guidelines for Prescribing Pain Medications[1] or at HHS Naloxone Co-prescribing Guidance.[2]

Co-prescribing naloxone along with overdose education has been shown to decrease opioid overdose fatalities. Naloxone is available as an injection and nasal spray, both of which are available on Cigna Medicare Advantage formularies. Naloxone injection products are available on generic tiers, and Narcan® nasal spray is covered on the preferred brand tier on most formularies.

FDA Safety Alert on Risks of Rapid Discontinuation of Opioids

On April 9, 2019, the Federal Food & Drug Administration (FDA) released a safety announcement regarding the risk of serious harm associated with abrupt discontinuation of opioids for patients physically dependent on these pain medications.[3] According to this warning, rapidly decreasing or discontinuing opioids can result in uncontrolled pain, withdrawal symptoms, psychological distress, and suicide.

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SAFETY UPDATES FOR OPIOID PAIN MEDICATIONS *CONTINUED*

The FDA recommends that health care professionals should not suddenly discontinue opioids in patients who are physically dependent and should consider the drug dose, duration of treatment, type of pain being treated, and physical and psychological attributes of the patient when developing a tapering regimen.

While no standard opioid tapering schedule exists, it is generally recommended to taper by increments of no more than 10-25% every two to four weeks. The FDA recommends health care professionals create tapering schedules that are patient-specific as well as offer ongoing patient support and frequent follow-up to avoid serious withdrawal symptoms, worsening pain, or psychological distress.

References

1. https://www.cdc.gov/drugoverdose/prescribing/guideline.html
2. https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf
3. United States Food & Drug Administration. "FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering." Posted 04/09/2019. Retrieved from https://www.fda.gov/downloads/Drugs/DrugSafety/UCM635492.pdf

Learn how Cigna is taking steps to reduce customers' opioid use by 25%.

Visit **https://www.Cigna.com/about-us/newsroom/studies-and-reports/fighting-opioid-epidemic.**

RESCUE INHALER UPDATE

Important update: Cigna helps patients afford medication. As of May 1, 2019, Cigna added generic albuterol HFA to Medicare Advantage formularies in addition to Ventolin® HFA and ProAir® (HFA or RespiClick®). The generic albuterol HFA is now available on the non-preferred drug tier at a lower cost to MAPD customers than the similar branded products.

According to current guidelines for asthma and chronic obstructive pulmonary disease (COPD) treatment, a short-acting bronchodilator should be prescribed to patients for immediate symptom relief as part of initial pharmacological management.[1, 2]

Rescue inhalers help control sudden symptoms of bronchospasms such as:

- Difficulty breathing
- Wheezing
- Shortness of breath
- Coughing
- Chest tightness

It is estimated that the majority of patients prescribed a rescue inhaler are using them incorrectly.[3] Common mistakes regarding metered-dose inhaler (MDI) use include:[4]

- Forgetting to shake the inhaler before use
- Not breathing in slow and steady
- Not waiting for at least a minute between inhalations
- Not lifting their chin prior to activation
- Not having a tight lip seal on the mouthpiece
- Not holding their breath after a puff

Review the proper technique for using an MDI rescue inhaler with your patients:[5]

1. Ensure inhaler has been primed
2. Shake inhaler
3. Remove cap (and insert into spacer if needed)

4. Exhale as much as possible
5. With inhaler in the upright position, place lips tightly over the mouthpiece of the inhaler
6. Lift chin slightly, press down on the canister while inhaling slowly and deeply through the mouth until lungs feel full
7. Hold breath for 10 seconds (or as long as possible)
8. Wait 1 minute before repeating (if necessary)
9. Replace the cap after use

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1. Singh D, Agusti A, Anzueto A, et al. Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Lung Disease: The GOLD Science Committee Report 2019. Eur Respir J. 2019 Mar 7. doi: 10.1183/13993003.00164-2019.
2. National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051). www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm
3. Roman-Rodriguez M, Metting E, Gacia-Pardo M, Kocks J, van der Molen T. Wrong inhalation technique is associated to poor asthma clinical outcomes. Is there room for improvement? Curr Opin Pulm Med 2019;25(1):18-26. doi: 10.1097/MCP.0000000000000540.
4. Common inhaler mistakes. Reviewed November 2018. https://www.asthma.org.uk/advice/inhalers-medicines-treatments/inhalers-and-spacers/common-inhaler-mistakes/. Accessed May 2, 2019.
5. Proair HFA® [package insert]. Horsham, PA: Teva Respiratory, LLC; April 2012.
6. RED BOOK Online. Micromedex Healthcare Series [database online]. Greenwood Village, CO: Truven Health Analytics; 2015. Accessed May 2, 2019.

STATIN Q&A

Providers – and patients – frequently ask questions about statins. At Cigna, we're here to help guide you to the right answers.

Q: How do I manage myalgia in a patient who would benefit from statin use?

A: Review the ACC/AHA algorithm for evaluating statin intolerance and safely reintroducing therapy.

Mild-Moderate Muscular Symptons

Muscle pain, tenderness, stiffness, cramping, weakness or fatigue.

↓

Stop statin immediately

↓

CHECK for alternate causes:

- Muscular disease
- Vitamin D deficiency
- Renal or hepatic dysfunction
- Hypothyroidism
- Rheumatologic disease
- Steroid myopathy

↓

If muscular symptoms resolve and no contraindication is found

↓

REINTRODUCE the original statin at the same or lower dose to determine causal relationship

↓

Causal relationship found → **STOP** original statin
WAIT for sympton resolution
RESUME low dose alternate statin

No relationship found → **RESUME** statin at original dose if muscular symptoms are from a non-statin cause or if the predisposing condition has resolved

Severe Muscle Pain

Severe muscle pain, tenderness, stiffness, cramping, weakness or fatigue

↓

Stop statin immediately

↓

TEST CK, creatinine, and urinalysis for myoglobinuria to confirm rhabdomyolysis

- Intolerance to one or more statins does not indicate intolerance to all statins.
- In addition to non-statin causes, onset of muscle symptoms in a patient who has previously tolerated statins can be caused by changes in their clinical status. Continue to consider secondary causes.
- Consider characteristics of each statin such as metabolism, lipophilicity, drug interactions, etc. when prescribing.

STATIN Q&A *continued*

Q: What alternative dosing regimens exist for statin use, and when should I use them?

A:

- It's preferable to use daily dosing of statins, since they have been studied and proven to reduce clinical events.
- Alternate-day dosing may improve the tolerability of statins in patients experiencing myalgias, and can reasonably be tried in patients unable to tolerate daily statin therapy.
- Small studies have evaluated every-other-day dosing of atorvastatin, fluvastatin 40mg, and rosuvastatin once weekly.
- Results suggest that to achieve similar LDL cholesterol lowering, the every-other-day dose needs to be on average twice that of the daily dose.
- As a best practice, consider re-prescribing with a new prescription that notes the new dosage to avoid patient confusion as to the correct regimen.

Q: Patients often ask about statins causing other conditions? What "talking points" can help address these concerns?

A:

- **Statins and diabetes (DM)** - Literature suggests that there is a small association between moderate to high-intensity statin use and the development of new onset type 2 diabetes (NODM). For every 498 patients treated with a statin per year, 1 patient develops NODM. However, cardiovascular disease is the leading cause of death in people with diabetes. Additionally, type 2 diabetes is considered a coronary heart disease risk equivalent. Based on the CARDS trial, over a 4-year period.
- **Statins and cognitive dysfunction** - The current literature reviewed by the Food and Drug Administration (FDA) does not suggest that statin use lead to clinically significant cognitive decline. According to the FDA, there was a small number of reports regarding cognitive impairment that were associated with statin use during the post-marketing phase. However, these symptoms were generally not serious and reversible upon discontinuation of statin therapy.
- **Statins and cataracts** - The American Academy of Ophthalmology states the available literature is conflicting and the data collected may not be generalized to the wider population. The authors concluded that patients should continue to take statins when medically indicated and should maintain regular eye examinations.
- **Statins and myopathy** - The American College of Cardiology (ACC) estimates that 10-20 patients in 10,000 are at risk for having muscle pain and weakness per year, which occurs symmetrically and proximally. When a patient does experience significant muscle toxicity with creatine kinase (CK) enzyme elevation, statin therapy should be discontinued. Once the patient's symptoms have resolved and CK level has returned to normal, the algorithm above is recommended by the ACC for management of statin intolerance.

https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2018/11/09/14/28/2018-guideline-on-management-of-blood-cholesterol

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THE EXPRESS SCRIPTS PHARMACY HOME DELIVERY HAS ITS BENEFITS

Now available for your Medicare Advantage and Prescription Drug Plan (PDP) patients

Great news. We are pleased to share that the Express Scripts Pharmacy℠ is now a Cigna preferred home delivery partner.[1] This means that your patients can start enjoying benefits such as:

More convenience	More peace of mind	More savings[2]
Fewer trips to the pharmacy mean patients can spend more time doing the things they love.	Having the right supply of medication on hand means patients are less likely to miss a dose.	$0 out-of-pocket costs for a 90-day supply of Tier 1 and Tier 2 medications.[3]

This is big. As the third-largest pharmacy in the United States, the Express Scripts Pharmacy serves over 10.5 million customers.[4] We look forward to having a partner who shares our commitment to the health, well-being and peace of mind of those we serve.

Next steps.

The Express Scripts Pharmacy is now available for your Cigna Medicare Advantage and PDP patients.

- E-prescribe or call **1-877-860-0982**, 7 a.m. – 11 p.m., Monday – Friday (CST)
- To learn more, visit **Express-Scripts.com**

Together, all the way.®

Cigna®

1. Other pharmacies are available in our network.
2. These Medicare Advantage home delivery copays vary based on patient's plan, medications and any assistance programs. PDP benefit differs.
3. Express Scripts Pharmacy may also contract with other Medicare Advantage plans. Deductible and/or coverage gap cost-sharing may apply. The Express Scripts Pharmacy has joined the network for Cigna Part D and Medicare Employer Group Pans, but the cost-sharing will vary. The Express Scripts Pharmacy is a trademark of Express Scripts Strategic Development, Inc.
4. Express-Scripts.com.

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UPDATING YOUR DIRECTORY INFORMATION

The Centers for Medicare & Medicaid Services (CMS) requires the maintenance of accurate data in provider directories. Up-to-date provider information allows Cigna Medicare Advantage to accurately generate provider directories, process claims, communicate with our network of providers, and help patients locate your practice.

Providers must notify their local Network Operations Representative in writing at least 30 days in advance, when possible, of changes, such as:

- Change in practice ownership or Federal Tax ID number
- Practice name change
- A change in practice address, phone or fax numbers
- Change in practice office hours
- New office site location
- When a provider joins or leaves the practice
- Primary Care Providers Only: If your practice is open or closed to new patients

Next steps

Double check or update your profile in CAQH (Council for Affordable Quality Healthcare) ProView at https://www.caqh.org/.

Is your information changing in the next 30 days? ? Please contact your local Network Operations representative. If you do not know who your local representative is, please call Provider Customer Service at **1-800-230-6138**.

EARN CME CREDITS WITH *VALUABLE INSIGHTS*

A CareAllies education series

CareAllies®, a Cigna business, has an extensive and successful history of innovative value-based provider collaborations. The CareAllies team works closely with providers to accelerate the transition to value-based care through their Provider engagement, Accountable care organization, Practice transformation, and Home-based care delivery solutions.

Whether you're just beginning your transition to value-based care, or are well on your way, you can increase your knowledge through *Valuable Insights*, a free, online education series that enables you to:

- Earn AMA PRA[1] Category 1 credits™ with *Valuable Insights* on-demand webcasts[2]
- Learn quickly and on the go with *Valuable Insights* podcasts
- Get industry updates from subject matter experts with *Valuable Insights* alerts

To access *Valuable Insights* resources, and receive notifications when new resources are posted, register at: http://events.careallies.com/valuableinsights. If you have questions, email **info@CareAllies.com**.

1 American Medical Association Physician's Recognition Award.

2 This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Illinois Academy of Family Physicians and CareAllies. The Illinois Academy of Family Physicians is accredited by the ACCME to provide continuing medical education for physicians.

HOME/FACILITY BOUND PREFERRED LAB VENDOR ANNOUNCED

Cigna Medicare Advantage has partnered with Central Clinical Labs (CCL) for your patients who are home or facility bound.

When your home or facility-bound patient needs lab services, please follow these (3) easy steps:

- Download the AZ Mobile Labs Order Form at ccllabs.com/forms/
- Fill out all sections on the form
- Fax to **1-480-990-1337**

CCL will draw the requested lab(s) the next business day, unless you note otherwise on the form.

Fasting

If lab(s) requested need the patient to be fasting. You will indicate by checking the YES check box next to the FASTING option. Fasting draws will get prioritized to be drawn between 6:00 a.m. - 9:00 a.m. The patient will receive a call the night before to provide fasting instructions. If the patient is not fasting, draws are generally done between 9:00 a.m. and 4:00 p.m. Results will be faxed to you once they are completed.

Standing orders

For standing orders, please check the Standing Order checkbox, and indicate how often test(s) need to be completed.

Online ordering

Online ordering is also available and will require the creation of a USER ID and password by CCL.

Please let your Network Operations Representative know Online Ordering is desired and they will work with CCL to obtain your USER ID and password.

Training

CCL can provide an in-person training for online portal use to the provider office. Please contact your Network Operations Representative to arrange this for you.

Important reminder

LabCorp is Cigna Medicare Advantage's preferred vendor for all outpatient lab orders. CCL should only be utilized by providers contracted to provide services for home/facility-bound patients.

AVOID CONCURRENT PRESCRIBING OF ANTICHOLINERGICS

Medications with anticholinergic properties are found across numerous drug classes and used to treat various health conditions. Among older adults, anticholinergic side effects do pose risks such as:

- Dizziness and blurred vision may increase fall and fracture risk.
- Confusion and memory impairment may further cognitive decline.
- Lesser side effects such as dry mouth may impact patient quality of life.

These risks can be elevated when multiple anticholinergic drugs are used simultaneously. It's important to help patients avoid concurrent use of multiple anticholinergic medications including: antihistamines, antiparkinsonian agents, skeletal muscle relaxants, antidepressants, antipsychotics, antiarrhythmics, antimuscarinics (urinary incontinence), antispasmodics, and antiemetics.

What can you do?

- Review patient medication lists, including medications prescribed by other clinicians, such as urologists or pain specialists.
- While some medications may not be replaced, one or more of the concurrent medications may be replaced to lower the risk of side effects.
- Reach out to the prescriber of other offending agent(s) to see if alternative medication could be selected.
- By working together to limit patient exposure to concurrent anticholinergic medications, you can avoid potential complications and negative outcomes from the additive side effects.

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AVOID CONCURRENT PRESCRIBING OF ANTICHOLINERGICS *continued*

Common drugs with moderate to strong anticholinergic effects

Antihistamines		
azelastine (Astelin)	cyproheptadine	doxylamine*
brompheniramine	dexbrompheniramine*	hydroxyzine
carbinoxamine	dexchlorpheniramine	meclizine*
chlorpheniramine*	dimehydrinate*	triprolidine*
clemastine*	diphenhydramine (oral)*	
Antiparkinsonian Agents		
benztropine (Cogentin)	trihexyphenidyl	
Skeletal Muscle Relaxants		
cyclobenzaprine (Flexeril)	methocarbamol (Robaxin)	orphenadrine (Norflex)
Antidepressants		
amitriptyline	doxepin (>6 mg/day)	paroxetine
amoxapine	imipramine	protriptyline
clomipramine	nortriptyline	trimipramine
desipramine		
Antipsychotics		
chlorpromazine (Thorazine)	olanzapine (Zyprexa)	thioridazine
clozapine (Clozaril)	perphenazine	trifluoperazine
loxapine		
Antiarrhythmic		
disopyramide (Norpace)		
Antimuscarinics (urinary incontinence)		
darifenacin (Enablex)	oxybutynin (Ditropan)	tolterodine (Detrol)
fesoterodine (Toviaz)	solifenacin (Vesicare)	trospium (Sanctura)
flavoxate (Urispas)		
Antispasmodics		
atropine (excludes ophthalmic and injectable)	dicyclomine (Bentyl)	propantheline
belladonna alkaloids	homatropine (excludes ophthalmic)	scopolamine (excludes ophthalmic)
clidinium-chlordiazepoxide	hyoscyamine (Anaspaz)	
Antiemetics		
prochlorperazine	promethazine	scopolamine (Transderm-Scop)

Note: list is not comprehensive

*OTC product

HELP KEEP YOUR PATIENTS ADHERENT TO PRESCRIBED MEDICATIONS

You've prescribed the right medications to help improve your patients' health – body and mind. The next step is to help keep your patients adherent to those medications. Based on claims data:

Less than 80% adherence to medications = accurate predictor of hospitalization due to disease.

What causes low adherence?

The top four roadblocks to patient adherence to prescribed medications are:

1. Forgetfulness
2. Perceived side effects
3. High cost of drugs
4. Perception that medication has little effect on their disease

What can you do to improve adherence?

1. **Ask questions.** Keeping an open dialogue with your patients about their medication adherence can open the doors to building solutions. Ask questions such as:
   - I know it must be difficult to take all your medications regularly. How often do you miss taking them?
   - Of the medications prescribed/listed, which ones are you taking?
2. **Don't underestimate the simplicity of a pillbox.** Studies have shown more than a 20% increase in adherence when pillboxes are used, and they can be the cheapest and easiest ways for patients to start a routine to stay adherent to the medications you have prescribed.
3. **Keep it simple.** The more complex a patient's medication regimen, the less adherent they become. Consider:
   - Once-daily alternatives: Lisinopril vs. Captopril, Metoprolol Succinate vs. Tartrate
   - Extended-release formulations: Metformin ER or Glipizide ER
   - Combination medications: Lisinopril/HCTZ, Metformin/Glipizide
   - High-potency statins: Rosuvastatin or Atorvastatin that have flexible morning dosing capabilities

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ADHERENT TO PRESCRIBED MEDICATIONS *continued*

Tip: Converting from three-times daily to once-daily regimens can increase adherence by 30%. Yes, most medications can be taken with each other, all at the same time.

4. **Consider cost.** There are plenty of great new medications out there, but if a patient cannot afford their medication, the clinical benefit of that drug is lost. Ask your patients if the cost of their medications is a concern to them, and always keep that in the forefront of your clinical decision-making process.

5. **Set expectations.** Fear of side effects and negative beliefs about medications can stop a drug before it's started. In a few simple sentences, discuss with your patient your clinical goals of starting this medication, what they can expect from the medication, common side effects and how long they last, and what side effects warrant a call to your office.

6. **Incorporate shared decision making.** Medicine is complicated, and ever-changing. Include your patients in your clinical decision-making thought process. Help them understand why you think a specific medication may be the best to achieve their health goals. If there are two choices, outline the risks and benefits of each medication, and allow them to participate in choosing which fits best into their lifestyle.

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doi:10.4065/mcp.2010.0575

2020 HEDIS CHART COLLECTION

Commitment to Care

Improving the quality of care that we provide to our customers continues to be a top goal. One way we measure improvement year-over-year is by using tools developed by the National Committee for Quality Assurance (NCQA). The NCQA creates measures for the Healthcare Effectiveness Data and Information Set (HEDIS®) that span six domains of care.

Helping You Focus on Patient Care

Every year we submit HEDIS data to NCQA that reflects the quality of care our customers receive. Data can be collected in a few ways, one of them being medical record reviews. While chart reviews can serve to supplement data that is not captured through claims, it is also a time-sensitive process that requires various touchpoints. For that reason, we continue to work on reducing the number of chart requests that go out every year.

Great Strides toward Improvement

In the last HEDIS season, we reduced chart requests by 30% across all our markets. That work is possible in great part by increasing remote access to provider Electronic Medical Records (EMRs) and the use of internal data sources. While we expand this process, we will continue to make chart requests in the most effective way possible.

What You Need to Know

- Patients are randomly selected for chart requests.
- HEDIS record collection is considered a health care operation under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, and patient authorization is not required.
- Initial requests for medical record reviews are delivered to provider offices in February of each year.

- The HEDIS medical record review is time sensitive.
- All Personal Health Information (PHI) is confidential, and only shared to the extent permitted by State and Federal laws.

If you have a secure EMR system, and allow us access through our secure network, HEDIS requests can be completed remotely. This is a more efficient process that can help minimize any disruption to your office. You can also send requested documentation via fax, mail, secure email, or electronic data feed.

Vendor Collaboration

Cigna Medicare Advantage has partnered with CIOX Health to retrieve medical records selected for the HEDIS data collection process in certain areas. Please note that we have a business associate agreement with CIOX and their employees. Any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding the confidentiality of patient records, as well as current HIPAA requirements.

What You Can Expect

Please anticipate receiving a phone call from CIOX to schedule the review. CIOX will work with you to minimize any disruptions in patient care activities. We appreciate your cooperation and look forward to continuing our work together.

ICD-10 EDUCATIONAL CORNER - RHEUMATOID ARTHRITIS

Rheumatoid arthritis (RA) is an auto autoimmune characterized by joint swelling and tenderness and destruction of synovial joints that may lead to severe disability and premature mortality.

RA FACTS

1.5 million people	**0.5-5%** of population	**$8.4 billion**	**$19.3 billion**
Affected by RA in the United States		Direct U.S. health care costs	U.S. health care costs, including RA consequences

RISK FACTORS

Social

- Obesity
- Cigarette smoking

Non-social

- Age 50-75
- Females are 2-3 times more at risk

SIGNS AND SYMPTOMS

Subjective findings

- Fatigue, malaise, anorexia, weight loss, fever if the disease is active.
- Chronic polyarthritis with joint pain.
- Boggy swelling.
- Stiffness in the morning lasting more than one hour.
- Duration of signs and symptoms is usually equal or greater than 6 weeks.
- Evaluate for RA if at least one joint has definite synovitis not explained by another condition.

Objective findings

- Usually bilateral and commonly involve the knee, hip, elbow, shoulder, ankle, wrists, metacarpal phalangeal (MCP), proximal interphalangeal (PIP), thumb Interphalangeal (IP), and 2nd-5th Metatarsophalangeal (MTP) joints.
- Serology for Rheumatoid factor (RF) and Anti-citrullinated protein antibody (ACPA), which is more specific of erosive disease.
- C-reactive protein (CRP) and Erythrocyte Sedimentation Rate (ESR) serology is indicative of acute phase of the disease.
- Joint imaging can also be performed to identify synovitis, periarticular erosions changes and establish joint baseline.
- Chest pain, shoulder pain, difficulty breathing, dry eyes and mouth, bumpy skin and weakness in knees and ankles.

ICD-10-CM

- RA is divided into two categories:
  - Without rheumatoid factor.
  - With rheumatoid factor.
- Further documentation is required to specify type of RA, such as:
  - Felty's syndrome.
  - Rheumatoid vasculitis.
  - Rheumatoid heart disease.
  - Rheumatoid myopathy.
  - Rheumatoid polyneuropathy.
  - RA with involvement of other organs and systems.
  - RA without organ or system involvement.
- Site and laterality should be included in the coding.

continued on next page

RHEUMATOID ARTHRITIS *CONTINUED*

TREATMENT

RA treatment is aimed at reducing the risk of disease progression and disability, by early initiation of Disease-Modifying Anti-Rheumatic Drugs (DMARD). In patients with RA, DMARD use is a quality indicator monitored by CMS as well as the health plan.

Questions?

Contact your Cigna Medicare Advantage market representative.

- Email **CCQI@HealthSpring.com**.
- Visit MedicareProviders.Cigna.com/icd-10.

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About our Chronic Care Quality Initiative (CCQI) Department:

The Chronic Care Quality Initiative team, under the MDQO Flag, is dedicated to assisting our provider network through providing resources to our network operations teams, medical directors, and provider education specialists. This team consists of subject matter experts in accurate diagnosis coding and documentation, technological resources within provider electronic health records (EHR). Also, this team develops and presents coding and documentation provider education as well as working with network PCP's EMR systems to allow them to participate in the 360 Comprehensive Assessment Exam using their own EMR systems.

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APPOINTMENT ACCESS AND AVAILABILITY STANDARDS

Review the checklist

Cigna-HealthSpring establishes standards for appointments to ensure patients have timely access to care. Please ensure that your office is following the standards below, which are all measured yearly by Cigna-HealthSpring.

Primary care access standards

Appointment type	Access standard
Urgent/emergent	Immediately
Non-urgent/non-emergent	Within one week
Routine and preventive	Within 30 business days
On-call response (after hours)	Within 30 minutes for emergency
Waiting time in office	30 minutes or less

Specialist access standards

Appointment type	Access standard
Urgent/emergent	Immediately
Non-urgent/non-emergent	Within one week
Elective	Within 30 days
High index of suspicion of malignancy	Less than seven days
Waiting time in office	30 minutes or less

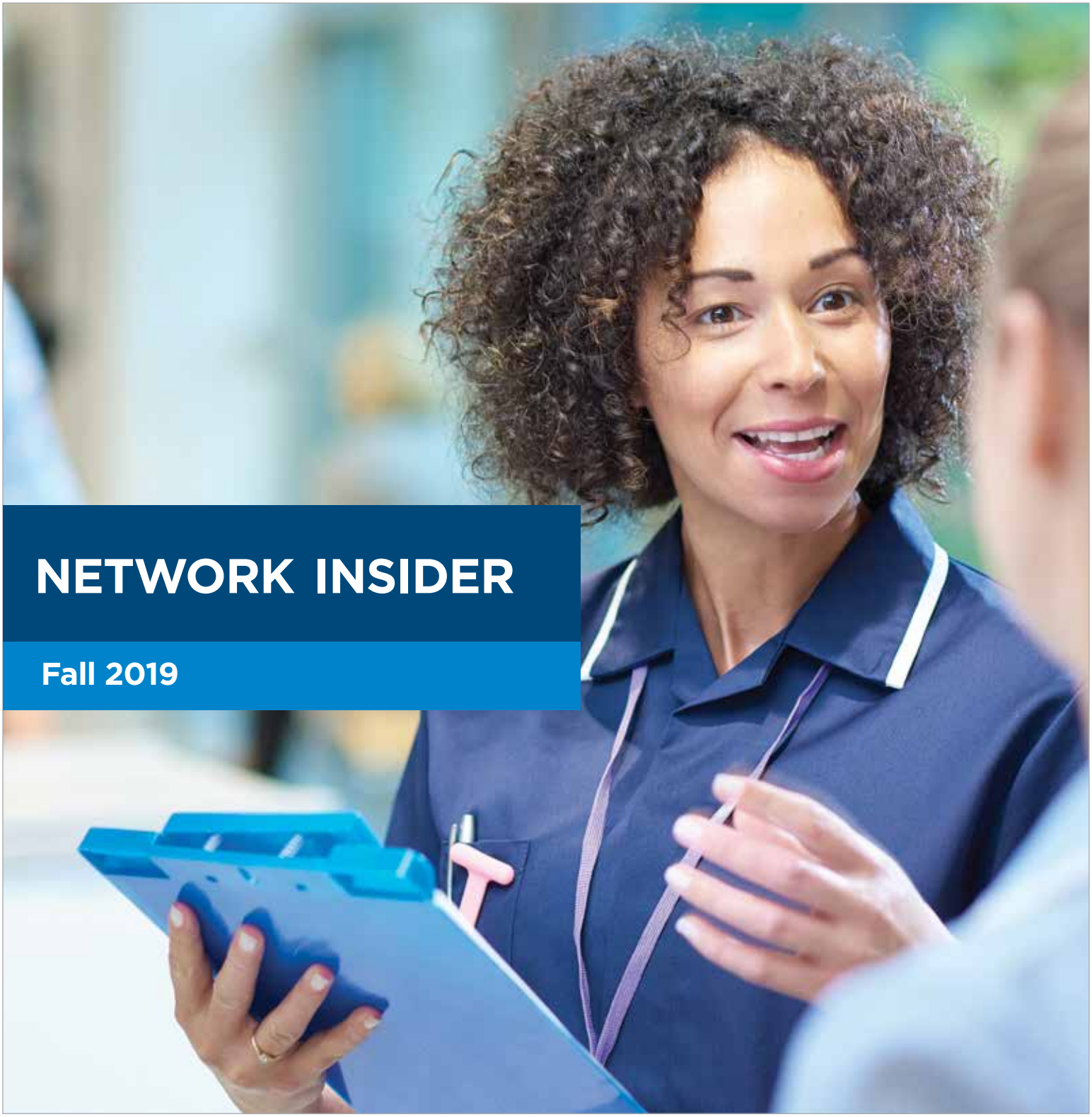
Behavioral health access standards

Appointment type	Access standard
Emergency and non-life-threatening	Within six hours of the referral
Urgent/symptomatic	Within 48 hours of the referral
Routine	Within 10 business days of the referral*

After-hours access standards

All participating providers must return telephone calls related to medical issues. Emergency calls must be returned within 30 minutes of the receipt of the telephone call. Nonemergency calls should be returned within a 24-hour time period. A reliable 24 hours a day/7 days a week answering service with a beeper or paging system, and on-call coverage arranged with another participating provider of the same specialty, is preferred.

*For detailed information on access standards, visit the online provider manual at MedicareProvider.Cigna.com/2019-provider-manual.



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