# NETWORK INSIDER

**Cigna-HealthSpring Texas STAR+PLUS News You Can Use**

## What is SNIP level validation?

Cigna-HealthSpring implemented SNIP level 1-7 validation edits and began rejecting claims and encounters that did not comply with HIPAA ASC X 12 version 5010 implementation guidelines that started on August 15th. Today these exceptions/rejections are being communicated as "Warnings" on rejection reports to clearinghouses and providers.

This is necessary to improve data quality in CMS submissions by ensuring claims meet the SNIP level technical specifications before being processed through Cigna-HealthSpring's adjudication system.

Your billing office or clearinghouse must correct the claim before resubmitting.

### What is HIPAA ASC X12 5010?

- HIPAA ASC X12 version 5010 and NCPDP version D.0 are the current sets of standards regulating electronic transmission of specific health care transactions, including eligibility, claim status, referrals, claims and remittances.
- Use of the 5010 version of ASC X12 and the NCPDP D.0 standard is required by federal law.
- What does "SNIP Level Validation" mean? The Workgroup for Electronic Data Interchange (WEDI) was formed by the Secretary of Health and Human Services (HHS) and was named in the HIPAA legislation as an advisor to HHS. The Strategic National Implementation Process (SNIP) is a WEDI project that collaboratively developed the industry standard testing levels to validate compliance with HIPAA.

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Cigna HealthSpring

TEXAS STAR+PLUS Your Health Plan ★ Your Choice

**MISDIRECTED CLAIMS:**
We strive for customer and provider centricity every day. Misdirected claims causes an adverse impact on both customers and providers. To learn more please visit:
**Cignahealthspring.com > Health Care Professionals > Misdirected Claims Information**

# What is SNIP level validation *(cont.)*

- There are seven levels of SNIP Level Validation

  Level 1: EDI syntax integrity testing

  Level 2: HIPAA syntactical requirement testing

  Level 3: Balancing

  Level 4: Situation testing

  Level 5: External code set testing

  Level 6: Product type or line of services

  Level 7: Implementation Guide-Specific Trading Partners

## How do I know if my claims are processing?

- If you've received a remittance advice or explanation of payment (EOP) from Cigna-HealthSpring, then your claim has met specifications and has been adjudicated.
- If you file electronically, your claims may be sent to your clearinghouse, but may NOT have been received by Cigna-HealthSpring. Therefore, it is imperative to check the daily Rejection Report from your clearinghouse for any claims that may not have been accepted by your clearinghouse, Cigna-HealthSpring's clearinghouse or Cigna-HealthSpring direct.
- If you are unsure about your Electronic Data Interchange (EDI) claims activity, contact your clearinghouse first to verify claims are being transmitted correctly.

## What's next?

You received a letter specifically announcing the implementation date of August 15th for this change. Please work with your clearinghouse or billing department to ensure data submitted to Cigna-HealthSpring is compliant as soon as possible. Until then, please refer all questions to your Network Operations representative.

# Tips for Cigna-HealthSpring Provider Portal

The 24-hour Provider Portal is an interactive site to access claims. It is administered by Change Healthcare. Participating providers can:

- Submit claims individually or by batch for CMS 1500 or UB04
- Check claim status individually or by batch
- Correct claims electronically
- Access ERA's and electronic EOP's
- Review reports and analytics
- Submit electronic appeals

- Providers must have a user ID and password to access the claims Provider Portal
- Access claims via HSConnect by selecting the new claim tab
- Cigna-HealthSpring claims presentations on the following topics are also located on our website.
- The Change Healthcare user guide is located on our website, under the claims tab
- Registrant must confirm their email in order to view claims under reporting and analytics.

Effective 9/1/15, Emdeon is now Change Healthcare

# Need additional training?

Refer to our websites to schedule an upcoming training sessions; for your convenience, presentations are also located on our website **starplus.cignahealthspring.com/ProviderEducation.**

- Provider Portal
- General STAR+PLUS
- Claims
- Authorizations
- Medicare-Medicaid Plan
- THSteps
- OIG
- Nursing Facility

# Retina screening for diabetes

## American Diabetes Association Guidelines

The American Diabetes Association (ADA) recommends patients with diabetes receive regular screenings for retinopathy with an ophthalmologist or optometrist.

## Retina screenings

PATIENTS WHO HAVE

| Diabetes prognosis | Dilated and comprehensive eye exam should be conducted | Subsequent eye exams should be conducted | Important notes |
|---|---|---|---|
| Diabetes Type 1 | Within five years of diagnosis | Yearly | |
| Diabetes Type 2 | Shortly after diagnosis | Yearly | |
| Well-controlled Diabetes Type1 or Type 2 | Follow guidelines above | Every two years if patient has had two normal exams | |
| Diabetes and progressing retinopathy | To be determined based on initial diagnosis of retinopathy | To be determined by patient's eye care professional but the ADA recommends "more frequently" | |
| Diabetes and planning to get pregnant | Before conception | Every trimester and up to one year postpartum based on evidence or degree of retinopathy | Women who are planning for or are currently pregnant should be counseled on increased risk retinopathy progression associated with pregnancy |
| Diabetes and currently pregnant | In first trimester, or as soon as possible | | |

(American Diabetes Association. Diabetes Care. 2016;39[Suppl 1]:S1-112).

# Disease-specific training schedule

Cigna-HealthSpring will host online disease-specific documentation and coding education meetings during 2016. These sessions are 15 to 30 minutes in duration. We have scheduled multiple dates and sessions to provide an opportunity for everyone to participate. Each session provides valuable insight about documenting and coding diseases more specifically. Clinicians, coding professionals and office administration staff are highly encouraged to attend. A question and answer session will follow each meeting.

| Date | Time CST | Topic |
|---|---|---|
| 08/16/16 | 7 a.m. | HTN |
| 08/16/16 | 11:30 a.m. | HTN |
| 08/16/16 | 3 p.m. | HTN |
| 09/20/16 | 7 a.m. | Z- Codes |
| 09/20/16 | 11:30 a.m. | Z- Codes |
| 09/20/16 | 3 p.m. | Z- Codes |
| 10/18/16 | 7 a.m. | Rheumatoid Arthritis |
| 10/18/16 | 11:30 a.m. | Rheumatoid Arthritis |

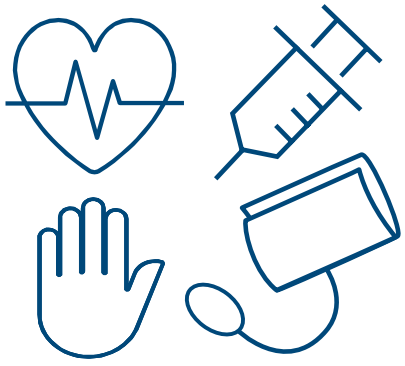
| Date | Time CST | Topic |
|---|---|---|
| 10/18/16 | 3 p.m. | Rheumatoid Arthritis |
| 11/15/16 | 7 a.m. | Substance Abuse & Dependency |
| 11/15/16 | 11:30 a.m. | Substance Abuse & Dependency |
| 11/15/16 | 3 p.m. | Substance Abuse & Dependency |
| 12/13/16 | 7 p.m. | Skin Ulcers |
| 12/13/16 | 11:30 a.m. | Skin Ulcers |
| 12/13/16 | 3 p.m. | Skin Ulcers |

**All meeting conference codes are 3085470487**

## Instructions to attend webinar:

1. Go to the web link: **go.mc.iconf.net/fl/0oxz6bf**
2. Set up the audio by:
   a. Selecting "Dial-In Now" from the pop-up window that appears
   b. Using your phone call: **1-888-534-8066**
   c. When prompted, dial the conference code: **3085470487**
   d. Click "Join Meeting" to gain access to the presentation

All times are Central Standard Time (Eastern Standard Time is 1 hour ahead of Central Standard Time, Mountain Standard Time is 1 hour behind Central Standard Time)



# ICD-10 coding tip reminders

- Use documentation language to ensure the highest level of specificity is ICD-10 code compatible
- Document laterality, organ sites, disease types, severity and dominance wherever applicable
- Avoid assigning non-specific ICD-10 codes whenever possible that could trigger a claim rejection

# ICD-10 coding tables

**2016 Non-reversible dementia codes**

| ICD-10-CM Code | Description | Definition / tips |
|---|---|---|
| G30.0 | Alzheimer's disease with early onset | Use additional code to identify:<br>• Delirium, if applicable (F05)<br>• Dementia with behavioral disturbance (F02.81)<br>• Dementia without behavioral disturbance (F02.80) |
| G30.1 | Alzheimer's disease with late onset | |
| G30.8 | Other Alzheimer's disease | |
| G30.9 | Alzheimer's disease, unspecified | |
| G31.01 | Pick's Disease<br>*Primary progressive aphasia*<br>*Progressive isolated aphasia* | Use additional code to identify:<br>• Dementia with behavioral disturbance (F02.81)<br>• Dementia without behavioral disturbance (F02.80) |
| G31.09 | Other Frontotemporal dementia<br>*Frontal Dementia* | |
| G31.83 | Dementia with Lewy bodies<br>*Dementia with Parkinsonism*<br>*Lewy body disease*<br>*Lewy body dementia* | |
| F01.50 | Vascular dementia without behavioral disturbance | • Vascular dementia as a result of infarction of the brain due to vascular disease, including hypertensive cerebrovascular disease (includes arteriosclerotic dementia)<br>• Code first the underlying physiological condition or sequelae of cerebro-vascular disease |
| F01.51 | Vascular dementia with behavioral disturbance | |

**2016 Reversible dementia codes**

| ICD-10-CM Code | Description |
|---|---|
| F10.27 | Alcohol dependence with alcohol-induced persisting dementia |
| F13.27 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia |
| F13.97 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia |
| F18.17 | Inhalant abuse with inhalant-induced dementia |
| F18.27 | Inhalant dependence with inhalant-induced dementia |
| F18.97 | Inhalant use, unspecified with inhalant-induced persisting dementia |
| F19.17 | Other psychoactive substance abuse with psychoactive substance-induced persisting dementia |
| F19.27 | Other psychoactive substance dependence with psychoactive substance-induced persisting dementia |
| F19.97 | Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia |

# ICD-10 resource center

## Cigna-HealthSpring employees

- **General resource**
  An ICD-10 page for all of Cigna-HealthSpring employees to help with general questions

## Network health care professionals

- CMS has an interactive educational website available to health care professionals:
  **roadto10.org**

- If a health care professional would like to see how ICD-9 codes translate into an ICD-10 world, please go to this free resource:
  **icd10data.com**

- CMS has released two short videos.

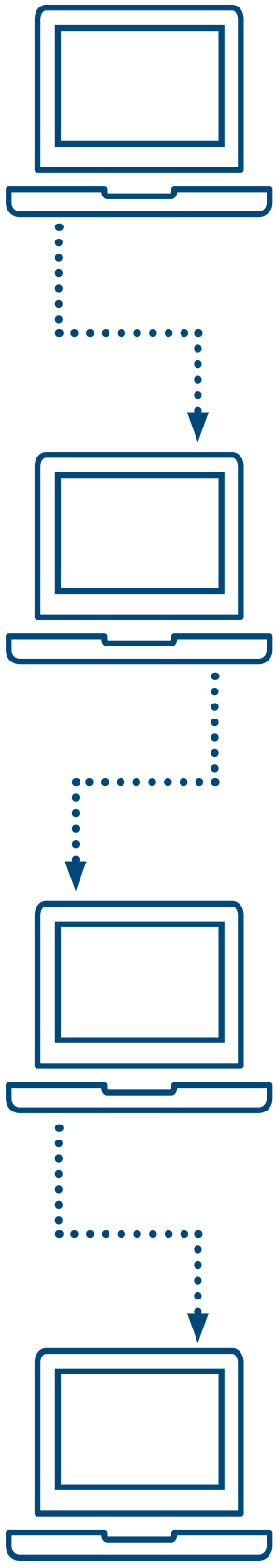
  - The first video is an overview of ICD-10's features:
    **youtube.com/watch?v=NNbTcMwrop8&feature=youtu.be**.

  - The second video shows how to use the new ICD-10 codes in diabetes to capture more specific clinical details:
    **youtube.com/watch?v=AEW2cXqXTSQ&feature=youtu.be**

- Essential clinician resources for the ICD-10 transition:
  **cigna.com/medicare/healthcare-professionals/icd-10**

- Clinical concepts for family practice:
  **cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsFamilyPractice1.pdf**

- Clinical concepts for internal medicine:
  **cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsInternalMedicine1.pdf**



# URGENT: TMHP provider re-enrollment

To avoid disenrollment on September 25, 2016, and possible disruption in claims payment, providers should submit a re-enrollment application to the state or TMHP today.

## Applications received on or before June 17, 2016:

To avoid potential disruption in payment, a complete re-enrollment application must be received on or before June 17, 2016 in order to be re-validated by September 24, 2016. For Texas Medicaid, this means all providers, including ordering and referring providers, who have not met all PPACA revalidation requirements must do so through re-enrollment by September 24, 2016. Complete applications that are received on or before June 17, 2016, will most likely complete the re-enrollment process by September 24, 2016. In the event that the re-enrollment process is not completed by September 24, 2016, and the provider is still working toward addressing identified deficiencies at that time, the provider will continue to remain enrolled in Texas Medicaid as long as the provider continues to respond to deficiency notifications within the defined time frame for response. Continued enrollment is contingent upon continuing to meet deficiency correction timelines and receiving final application approval. Providers should submit a re-enrollment application to the state or TMHP today.

## Applications received after June 17, 2016:

Texas Medicaid will normally process complete applications received on or after June 17, 2016; however, Texas Medicaid cannot guarantee that those applications will be completely processed by the September 24, 2016 deadline. If final approval on an application received after June 17, 2016 is not completed by September 24, 2016, the provider will be dis-enrolled from Texas Medicaid. Providers including, but not limited to, ordering and referring providers, will be dis-enrolled from Texas Medicaid with an effective date of September 25, 2016 if the application is received after June 17, 2016, and a final determination on the application is pending.

Though these applications will continue to be processed, a gap in enrollment will exist between September 25, 2016, and the date the application is approved. Providers whose applications are denied will remain dis-enrolled with an effective date of September 25, 2016. Providers with a gap in Medicaid enrollment will not be eligible to receive reimbursement for claims with dates of service during the time the provider is not enrolled in Texas Medicaid. If the re-enrollment application is approved at a later date, the re-enrollment date will be the date the application was approved. The effective date will not be retroactive to the date the provider was dis-enrolled. Additionally, dis-enrolled providers will not be eligible to participate in Medicaid managed care organizations (MCOs) or dental maintenance organizations (DMOs) during the dis-enrolled period.

Texas Medicaid must comply with federal regulations which require all providers to revalidate their enrollment information every three to five years. In accordance with this mandate, the Centers for Medicare & Medicaid Services (CMS) require that states complete the initial re-enrollment of all providers by the new extended date, September 25, 2016. For Texas Medicaid, any provider enrolled before January 1, 2013, must be fully re-enrolled September 25, 2016. Providers should begin this process immediately. Additional information can be found on the following websites.

**For Acute Providers:**
**tmhp.com/Pages/Topics/ACA.aspx**

**For LTSS Providers:**
**dads.state.tx.us/providers/mpre/**

Providers who fail to completely re-enroll by September 25, 2016 will be considered non-participating with Cigna-HealthSpring, and will not receive reimbursement.

**Important!** Submit re-enrollment application by this date to ensure timely completion.

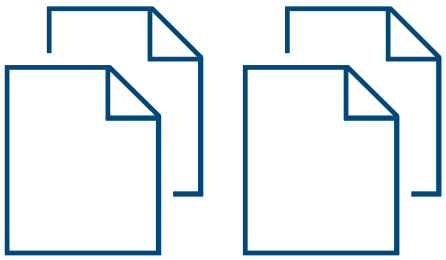
# Nursing facility news

For applied income adjustments and RUG level changes adjustments, you may use the payment dispute form.

These forms can be found on our websites:

**starplus.cignahealthspring.com**

**cigna.com/medicare/healthcare-professionals/tx-mmp**



# 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..
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 professional shall be discriminated against by Cigna-HealthSpring in reimbursement, participation or based on the population served.

# Non-emergent ambulance services for nursing facilities

Requests for prior authorization for non-emergent ambulance transports are to be submitted by the Nursing Facility. An ambulance provider may NOT request a prior authorization for non-emergent ambulance transports. The ambulance provider is ultimately responsible for ensuring that a prior authorization has been obtained prior to transport. Non-payment may result for services provided without a prior authorization or when the authorization request is denied by the MCO.

# National plan and provider enumeration system (NPPES)

The National Provider Identifier (NPI) registry enables you to search for a provider's NPPES information. All information produced by the NPI registry is provided in accordance with the NPPES data dissemination notice. Information in the NPI registry is updated daily. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or legal business name. There is no charge to use the NPI registry.

**Important:** if you have changed NPIs, taxonomy, specialty, etc., please change the information with NPPES.

**nppes.cms.hhs.gov** or call **1-800-465-3203**

# Payment dispute form

Cigna-HealthSpring has implemented a new way to request a claim to be reconsidered when a provider is disputing and/or requesting a claim to be reviewed for denial or partial payment. Examples of the denial reasons are listed below.

- For "timely filing" but provider has proof of timely filing
- For "no auth on file" but provider has auth listed
- For "benefit not covered" but per TMHP it is payable
- For "no coverage" but member was active during the DOS
- Provider not being paid at correct reimbursement rate, but we paid incorrectly
- For "no active provider contract" and provider has an active contract listed
- For insufficient units, but per authorization on file, there are units available
- For "no member match" but the member was active for DOS, and DOB, ID and name all match the original submission
- Applied income changes

For a full list or if you have questions, please contact Provider Services, Monday to Friday, 8 a.m. to 5 p.m. Central Time at **877-653-0331**.

You can also find this form on our websites:

Fax the request to Cigna-HealthSpring STAR+PLUS at **1-877-809-0783**

Mail the request to:

**Cigna-HealthSpring**
**Payment Dispute Unit**
**PO Box 211088**
**Bedford, TX 76095**

Requests for reconsideration must be made within 60 days from the date of remittance of the Explanation of Payment (EOP).

Reconsideration must be filed within 120 days (for Medicaid plans) from the date of the disposition or the remittance of Explanation of Payment (EOP). Out-of-State providers must file within 365 days.

# The difference between a corrected claim, payment disputes and appeals

**Corrected claim** – A corrected claim is a claim that has already been adjudicated, whether paid or denied. A provider would submit a corrected claim if the original claim adjudicated needs to be changed. e.g., provider billed with an incorrect date of service/incorrect number of units

**Payment disputes** – Payment disputes are requests to reconsider a claim denial for administrative decision or the provider is disputing and/or requesting a claim to be reviewed for denial or partial payment. Administrative decisions include billing issues such as incorrect modifiers, diagnostic codes, overpayments, applied income, underpayments etc. (all non-medical reasons).

**Appeals** – An appeal is a claim that has been previously adjudicated as a clean claim and the provider is appealing the disposition through written notification to Cigna-HealthSpring in accordance with the provider claim appeal process as defined in the Cigna-HealthSpring provider manual.

# Authorization reminders

- Please remember to provide supporting medical records from the ordering physician's office to substantiate the need for the services, supplies or equipment being requested for STAR+PLUS plans. Records from the home health or DME vendors are not sufficient. If we do not receive adequate documentation, the request may be denied.
- Behavioral health medications: Providers must obtain the proper prior authorizations for prescriptions written for our members.

# Access to care is important

## Let's keep our standards high across the board

Primary Care Physicians must have their primary office open to receive Cigna-HealthSpring customers for five days and at least 20 hours per week. In addition, and when medically necessary, the PCP must ensure that coverage is available 24 hours a day, seven days a week. Offices must be able to schedule appointments for Cigna-HealthSpring customers at least two months in advance of appointment. PCP's must arrange coverage during absences with another Cigna-HealthSpring participating provider in an appropriate specialty documented on the Provider Application and agreed upon in the Provider Agreement.

| Appointment type | Primary care 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 |
| **Appointment type** | **Specialty care 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 |
| **Appointment type** | **Behavioral health access standard** |
| Emergency and non-life threatening | Within 6 hours of referral |
| Urgent/symptomatic | Within 48 hours of referral |
| Routine | Within 10 business days of referral* |
| Waiting time in office | 30 minutes or less |

## After-hours access standards

All participating providers must return phone calls related to medical issues. Emergency calls must be returned within 30 minutes. Non-emergency calls should be returned within 24 hours. A reliable 24/7 answering service with a beeper or paging system and on-call coverage arranged with another participating provider of the same specialty is preferred.

# Practice changes

## What to report – and why

Help us make sure we have your practice information correct and up-to-date. Timely reporting of changes in your practice helps in two important ways:

1. Ensures your listing is correct in the Provider Directory
2. Avoids potential claims denials for your physicians and you

Please contact your Network Operations representative to report any of the following changes:

1. Practice address
2. Billing address
3. Fax or phone number
4. Hospital affiliations
5. Practice name
6. Providers joining or leaving the practice (including retirement or death)
7. Provider taking a leave of absence
8. Practice mergers and/or acquisitions
9. Adding or closing a practice location
10. Tax Identification Number (please include W-9 form)
11. NPI number changes and additions
12. Changes in practice office hours, practice limitations, or gender limitations

**Important:** Please provide written notice of practice changes to Cigna-HealthSpring no less than 90 days in advance. If 90 days advance notice is not feasible, please inform us as soon as possible.

## Provider Data Validation (PDV) team contact list

| Market | Email | Fax Number |
|---|---|---|
| TN<br>NWGA<br>KC | TNDocs@healthspring.com | 855-595-2211/860-907-8933 |
| IL MA<br>IL MMAI<br>IL ICP<br>IN<br>TX MMP<br>TX STAR+PLUS | ProviderDataValidation@healthspring.com | 877-440-9336 |
| AL<br>GA<br>NFL<br>SMS<br>NC<br>SC | ALPDVTeam@healthspring.com | 877-720-3859 |
| TX MA | TX_PDV_Team@healthspring.com | 855-694-2717 |
| MD<br>DC<br>DE<br>PA | MAPA_PDV_Team@healthspring.com | 866-790-8599 |

# NETWORK INSIDER

## Summer 2016



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NETWORK INSIDER

Cigna HealthSpring

TEXAS STAR PLUS
Your Health Plan ★ Your Choice

500 Great Circle Road
Nashville, TN 37228

Summer 2016