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MVP HEALTH CARE®

MVP Provider Directory

You can search the current MVP Provider Network for primary care physicians and specialists. Visit **mvphealthcare.com** and select *Find a Doctor*.

$ Un-Cashed Checks?

Visit **longlostmoney.com** to see if MVP has any un-cashed checks in your name or in the name of your business.

MVP Professional Relations

Vermont   **1-800-380-3530**

Denise V. Gonick
President & CEO
MVP Health Care, Inc.

We welcome your comments.

HEALTHY PRACTICES
MVP HEALTH CARE
PROFESSIONAL RELATIONS DEPT
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mvphealthcare.com

Professional Relations Updates

CMS Medicare Benefits and Beneficiary Protections for Plan-Directed Care

Per the Centers for Medicare & Medicaid Services (CMS) regulation, when an MVP Medicare Advantage plan member receives items and services from an MVP-contracted provider or is referred to a non-contracted provider by an MVP-contracted provider, he or she will generally be deemed to believe that those items or services are covered benefits under his or her Medicare Advantage policy. The member can only be held liable for the applicable in plan-cost share (co-pay, co-insurance, or deductible).

If you, as an MVP-contracted provider believe an item or service may not be covered or could be covered only under specific conditions, your office or the member must request a pre-service organization determination from MVP. The Medicare Advanced Beneficiary Notice or other forms of prior notice are not applicable to Medicare Advantage members.

CMS expects providers to coordinate with MVP before referring a patient to a non-contracted provider. This important step will ensure that our members are receiving medically-necessary services covered by their MVP Medicare Advantage plan.

Visit **cms.gov** and search for *Medicare Managed Care Manual, Chapter 4- Benefits and Beneficiary Protections, Section 16*0 for more information.

If you need to request a pre-service organization determination prior to providing a service or referring a member to a non-contracted provider, please call **585-325-3114** or **1-800-999-3920**.

MVP Awarded a CORE-Certification Seal from CAQH for Compliance with EFT/ERA CORE Operating Rules

MVP Health Care is excited to announce that we have received our CAQH® Committee on Operating Rules for Information Exchange (CORE®) PHASE III Health Plan Certification Seal, demonstrating our commitment to comply with EFT/ERA CORE Operating Rules. MVP applied for CORE Certification status because it supports the CORE mission, collaborative industry approach, and administrative simplification objectives.

CAQH, a not-for-profit alliance of health plans and trade associations, launched CORE to promote health plan-provider interoperability and improve provider access to administrative information.

MVP strived for CORE Certification status in order to support the CORE mission, to accelerate the transformation of business processes in health care through collaboration, innovation, and a commitment to ensuring value across stakeholders.

Achieving the CORE-Certification Seal reinforces MVP's dedication to exchange electronic administrative data in compliance with the CORE rules. CAQH currently

awards a CORE-Certification Seal to health plans that complete the Phase I, Phase II, and Phase III certification processes. The Phase III Seal indicates that MVP is certified as operating in compliance with Phase I, Phase II, and Phase III rules.

MVP works diligently to ensure that our systems, supporting business processes, policies, and procedures successfully meet the implementation standards and deadlines mandated by the Department of Health and Human Services. Additionally, MVP is committed to maintaining the integrity and security of health care data in accordance with all applicable laws and regulations.

Phase III of the CAQH CORE Operating rules is specific to Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). MVP provides EFT and ERA through PaySpan®. This service is provided at no cost to providers and allows online enrollment, saving time and ensuring faster payments.

If you have any questions about EFT/ERA, or if you need assistance from MVP during the set-up process with PaySpan, please contact your MVP Professional Relations or Facilities Representative.

In-Office Procedure and Inpatient Surgery List as of August 1, 2017

As of August 1, 2017, MVP will be archiving the Ambulatory Surgery List and replacing it with an Inpatient Surgery List.

Effective for all lines of business, the new Inpatient Surgery List specifies the CPT/HCPCS codes that MVP will reimburse when performed in the inpatient hospital setting. Claims submitted with an inpatient place of service for codes not on this list will not be approved unless prior authorization was obtained. Medical necessity prior authorization requirements remain the same.

All procedures are subject to the members plan type and benefits.

The In-Office Procedure List details the CPT codes that MVP requires to be performed in the physician's office remains the same. Claims submitted with a place of service other than the physician's office will not be approved unless prior authorization is obtained.

To access the Inpatient list, visit **mvphealthcare.com** and select *Providers*, then *Reference Library*, then *MVP Inpatient Surgical list (Effective August 1, 2017)*.

naviHealth Services Available for Medicare Advantage Members

Effective July 1, 2017, naviHealth, Inc. will provide Utilization Management for Skilled Nursing Facility (SNF), Acute Inpatient Rehabilitation (AIR,) and Home Health services for Medicare Advantage members only. naviHealth staff will be located in each of the MVP regions to visit facilities and manage the transitions. To contact naviHealth, visit **naviHealth.us** or call **1-844-411-2883**.

Provider Demographic Changes

MVP makes every effort to ensure a provider's demographic information is accurate in our systems. If you or your practice have changes in demographic and/or participation status, it is important to promptly notify MVP.

Examples of status changes are:
• No longer accepting patients
• Changes of address, phone number, or tax ID number

To report demographic changes to MVP, please complete a *Provider Change of Information* form. To download the form, visit **mvphealthcare.com** and select *Providers*, then *Forms*, and then the appropriate form under *Provider Demographic Change Forms*. Please return the completed demographic change form to the appropriate email.

East New York and Massachusetts
eastpr@mvphealthcare.com

Central, Mid-State, or Southern Tier New York
centralprdept@mvphealthcare.com

Rochester
RocProviderChanges@mvphealthcare.com

Mid-Hudson New York
MidHudsonprdept@mvphealthcare.com

Vermont
vpr@mvphealthcare.com

For more information, see Section 4 of the *MVP Provider Resource Manual*.

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Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the March meeting. Some of the medical policies may reflect new technology while others clarify existing benefits. *Healthy Practices* and/or *FastFax* will continue to inform your office about new and updated medical policies. MVP encourages your office to look at all of the revisions and updates on a regular basis in the *Benefits Interpretation Manual (BIM)*. To access the *Benefits Interpretation Manual*, visit **mvphealthcare.com** and *Sign In/Register,* then select *Resources*. The *Current Updates* page of the BIM lists all medical policy updates. If you have questions regarding the medical policies or wish to obtain a paper copy of a policy, contact your MVP Professional Relations Representative.

Medical Policy Updates Effective August 1, 2017

BRCA Testing (Genetic Testing for Susceptibility to Breast and Ovarian Cancer): The BRCA Testing medical policy was updated to include the most recent changes from the National Comprehensive Cancer Network (NCCN) Guidelines in Oncology: Genetic/Familial High-Risk Assessment: Breast and Ovarian Version 2.2017.

Cell-Free Fetal DNA-Based Prenatal Screening for Fetal Aneuploidy: The Exclusion section of the medical policy was updated to include those services considered experimental/investigational as follows:

- Non-invasive prenatal testing using cell-free DNA circulating in maternal blood is not indicated for screening or detection of microdeletions or other chromosomal disorders (e.g., other trisomies).
- Non-invasive prenatal testing using cell-free DNA circulating in maternal blood for screening or detection of sex chromosome aneuploidies
- Non-invasive prenatal testing (NPIT) using cell-free fetal DNA in maternal plasma for trisomy 13 and/or 18 (M code 0009M) in the absence of trisomy 21.

There are no criteria/indications changes to the medical policy.

Eating Disorders: The medical policy was updated to clarify the Acute Inpatient Admission to a Medical Bed. MVP manages the medical part of the hospital admission and Beacon Health Option manages the behavioral health component of the hospital admission. A patient must meet Intermural inpatient level of care criteria. Individuals with medical instability will be managed by the individual's medical physician. When the individual is medically stable and does not require 24-hour medical and/or nursing care monitoring/procedures, the individual's care will then be managed by the behavioral health provider.

Endoscopy (Esophagogastroduodenoscopy and Colonoscopy): The medical policy was updated with additional criteria to the following sections:

- Diagnostic Esophagogastroduodenoscopy (EGD)
  - Evaluation of esophageal masses and for directing biopsies for diagnosing esophageal cancer.
  - Evaluation of persons with signs or symptoms of loco-regional recurrence after resection of esophageal cancer.
- Screening Colonoscopy
  - Screening of individuals with increased risk based on positive family history;
  - One first-degree relative with colorectal cancer (CRC) less than 60 years of age and under or two first-degree relatives with CRC at any age: colonoscopy beginning at age 40 years or 10 years before earliest diagnosis of CRC, repeat colonoscopy every five years or if positive, repeat per colonoscopy findings;
  - First-degree relative with CRC over 60 years of age: colonoscopy beginning at age 50 years, repeat colonoscopy every five to ten years or if positive, repeat per colonoscopy findings.

Endovascular Repair of Aortic Aneurysms and Percutaneous Transluminal Angioplasty: The Exclusion section of the medical policy was updated to include those services considered experimental/investigational as follows:

- Implanted wireless physiologic pressure sensor (EndoSure Wireless AAA Pressure Measurement System) in aneurysmal sac during endovascular repair.
- Non-invasive physiologic study of implanted wireless pressure sensor (CardioMEMS EndoSure Electronics System) in aneurysmal sac following endovascular repair.

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Medical Policies Approved without Changes in May 2017

Artificial Intervertebral Discs Clerical and Lumbar
Cochlear Implants and Osseointegrated Devices
Hospice Care
Imaging Procedures
Personal Care and Consumer Directed Services
Private Duty Nursing

Clinical Guidelines Approved by the Quality Improvement Committee in May 2017

Major Depression in Adults in Primary Care: As part of MVP's continuing Quality Improvement Program, adopted the Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care guideline. The ICSI guideline contains a one-page algorithm which is followed by supporting annotations and evidence. A Quality Improvement Support section is included that contains related aims, measures, and specifications as well as implementation recommendations. The ICSI guideline was last updated in March 2016. A summary of the changes to the prior version can be found at **icsi.org**.

Management of the Adult Patient with Diabetes: As part of MVP's continuing Quality Improvement Program, adopted diabetes guidelines based on the most recent recommendations of the American Diabetes Association (ADA). The ADA 2017 updates to the Clinical Practice Recommendations included some changes either due to new evidence or to clarify a recommendation. The key recommendation for blood cholesterol management was updated to be consistent with American College of Cardiology (ACC)/American Heart Association (AHA) Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults.

Pharmacy Updates

Pain Medication Policy Update Effective July 1, 2017

The following applies to Commercial, Marketplace, and Medicaid members.

Opioids for chronic use (greater than three months) that exceed the quantity limits listed in the MVP Pain Medication policy will need to meet the following requirements:

- Must have current provider-patient opioid treatment agreement and documented pain management treatment plan that addresses taper.
- Must have documented verification that the Prescription Monitoring Program Registry was checked if available prior to each prescription.
- Must have addressed opioid overdose risk if the morphine equivalent dose (MED) is greater than 90mg per day.

Methadone

Methadone will now require prior authorization and must meet the following requirements as it is considered a second-line agent in the treatment of severe chronic pain:

- Patient must have documented moderate to severe pain.
- Must have failed two separate trials of long-acting opioid agents.
- Must be prescribed by a pain management specialist or specialist familiar with the use of methadone.

- If methadone is prescribed in combination with other CNS depressants, the prescriber must acknowledge the benefits outweighs the risk of the co-administration.

If above criteria is not met, short term approvals will be granted to allow time to safely taper the medication.

Four Opioid Prescriptions in 30 Days Rule

After four opioid prescriptions are filled in a 30 day period, all additional prescriptions will reject for the remainder of the 30 days. All additional opioid prescriptions attempted to be filled during the remainder of the 30-day period will require prior authorization.

Policy Updates Effective July 1, 2017

Intranasal Corticosteroids: Veramyst removed from policy as it is no longer available.

Inhaled Corticosteroids and Combinations: Policy archived.

Xolair: Age for the treatment of asthma updated to six years and older.

Cystic Fibrosis (select agents for inhalation): Exclusion FEV1 updated for Tobi Podhaler.

Cystic Fibrosis (select oral agents): Age range for Kalydeco updated to two years and older. Age range for Orkambi updated to six years and older.

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Idiopathic Pulmonary Fibrosis: No changes.

Cough and Cold Products (Brand): No changes.

Epinephrine Auto-Injectors: Auvi-Q is excluded from coverage.

Preventive Services-Medications: Age range for coverage of aspirin updated per the United States Preventive Services Task Force (USPSTF) recommendation.

Crohn's Disease and Ulcerative Colitis, Select Agents: Stelara IV and Stelara prefilled syringes added to policy.

Formulary Updated for Commercial, Marketplace, and Medicaid

New drugs–recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid plans.

Drug Name	Indication
Trulance	Chronic idiopathic constipation
Emflaza	Duchenne muscular dystrophy
Xermelo	Carcinoid syndrome diarrhea
Kisqali	Advanced breast cancer
Bavencio	Merkel cell carcinoma
Dupixent	Atopic dermatitis
Ocrevus	Multiple Sclerosis
Triferic	Iron replacement in HDD-CKD
Xultophy	Type 2 DM
Eloctate	Hemophilia A
Arymo ER	Pain
Rhofade	Rosacea

Drugs Added to Formulary
Tier 1 for Commercial/Medicaid and
Tier 2 for Marketplace
Flurandrenolide ointment
Desvenlafaxine SR (generic Pristiq)
Prednisolone solution 10mg/5ml
Prednisolone solution 20mg/5ml
Mibelis 24 Fe

Drugs Removed from Prior Authorization
Otovel

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