HealthyPractices™

MVP HEALTH CARE

A Bi-Monthly Publication for MVP-Participating Health Care® Providers

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Vermont

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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
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We welcome your comments.

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MVPPR0001 (10/2017)

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 160* 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 **1-800-684-9286**.

Provider Satisfaction Survey Mailing

MVP has mailed our annual General Satisfaction Survey to all of our providers. The survey was sent at the end of October. If you have not received it as of yet, please be look for it.

All respondents are entered into a drawing for a $50 VISA gift card. MVP values your feedback, and we would appreciate it if you and your staff could take a few moments to complete the survey and return it to MVP.

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*,

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(*Provider Demographic Changes* *continued from page 1)*

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*.

Quality Improvement Updates

Monitoring Kidney Disease in Patients with Diabetes

The Centers for Medicare and Medicare Services monitor the quality of care that Medicare members in Medicare Advantage Plans receive from their contracted physicians. These results are compared across Medicare Advantage plans across the country through the Medicare Star Ratings. One measure that is included in the Star Rating is Kidney Disease Monitoring in patients with Diabetes.

We want to thank you for the excellent care our physicians and ancillary providers continue to give all MVP members, your patients. This is a measure that we did not perform as well in this year. We do want to remind everyone about documentation and coding that is necessary to show that services are given.

A *Fast Fax* was sent earlier this year notifying physicians that MVP has created reference guidelines that will provide you and your staff with helpful tools that explain HEDIS measures as well as providing the CPT, HCPCS, and ICD-10 codes that count toward the completion of these measures.

To find this coding reference guide, visit **mvphealthcare.com** and select *Providers*, then *Quality Programs*, then *HEDIS 2017 Coding Reference Guide for Primary Care*. Information about Kidney Disease (Nephropathy) Monitoring in patients with Diabetes can be found on pages 16–17.

HEDIS/QARR Measure Spotlight

Healthcare Effectiveness Data & Information Set (HEDIS) is a nationally recognized set of health care quality measures that contribute significantly to MVP's NCQA (National Committee for Quality Assurance) accreditation score. MVP collects HEDIS data from claims information and by chart review in many offices across our service area. MVP monitors its performance in these measures on an ongoing basis and submits results to NCQA annually. The state and federal governments also monitor the HEDIS measure results to assess the quality of care that the members of health plans receive from their contracted physicians. The CMS Star Rating Program and New York State Quality Assurance Reporting Requirements (QARR) programs are two examples.

Results are also produced at the practice level for use in clinical reporting, allowing providers to see how they compare in relation to the health plan averages. Below is information on select HEDIS measures that relate to Behavioral Health.

If you have questions on compliance with any HEDIS measure, please contact Michael Farina at **518-388-2463** or **mfarina@mvphealthcare.com**.

AMM–Antidepressant Medication Management

This measure focuses on members with a diagnosis of Major Depression who were treated with an antidepressant medication (ages 18 and over). Two medication adherence rates are reported:

1. **Effective Acute Phase Treatment**–members must remain on an antidepressant medication for at least 84 days (12 weeks).
2. **Effective Continuation Phase Treatment**–members must remain on an antidepressant medication for at least 180 days (six months).

ADHD–Follow-Up Care for Children Prescribed ADHD Medication

This measure focuses on children ages 6–12 who were newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication. Two rates for follow-up visits are reported:

1. **Initiation Phase**–children must have one follow-up visit with practitioner with prescribing authority within 30-days from when the medication was dispensed.
2. **Continuation and Maintenance Phase**–in addition to the initial visit within 30 days, children must have two

additional visits within nine months after the Initiation Phase has ended.

We understand the challenges providers face to help educate patients and influence behavior change; especially when dealing with mental illness/substance abuse. We have various resources available to support your work—some of these are described below.

Primary Care Quality Reports

MVP produces several reports for physicians:

- **The Accountable Care Metrics (ACM)** report currently includes the AMM and ADHD measures. This report depicts the practices rate for each measure, compared to the health plan mean and goal.
- **The Gaps in Care** reports help providers identify members in need of certain visits/screenings. These reports are provided in Microsoft Excel and PDF format so that the practice can manipulate the patient lists to best suit their needs. They are delivered monthly via secure e-mail.

Throughout the year Clinical Reporting Coordinators visit practices to review their results and provide them with suggestions and tools to help improve their performance. For any questions on these reports or to schedule a visit, please contact Mike Farina at **518-388-2463** or **mfarina@mvphealthcare.com**.

Clinical Guidelines and Tools

MVP has adopted clinical practice guidelines that address the behavioral health HEDIS measures. To access these guidelines, visit **mvphealthcare.com** and select *Providers*, then *Quality Programs*, then *Provider Quality Improvement Manual*, then *Behavioral Health*. Also located here are several tools providers can use for screening and treatment of these conditions.

Coordination of Care with Behavioral Health Providers

Individuals who are depressed or have other mental health/substance abuse issues often have trouble following through with recommendations. If you have referred a patient to a behavioral health provider, it is important that you follow-up with the patient to ensure the appointment was made in a timely manner and the individual attended it.

MVP strongly encourages Behavioral Health specialists to communicate with the members PCP. This allows both health care providers to have a complete overview of the member's health issues and concerns, in addition to coordinating any medications the member may receive. Communication and coordination among providers is essential to help reduce medical errors and improve quality, safety, and continuity of care.

Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the September 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 December 1, 2017

Acute Inpatient Rehabilitation: There are no changes to the medical policy criteria.

Alopecia Treatment *NEW Policy*: Alopecia Treatment is a new policy effective December 1, 2017. This policy addresses medical treatment for alopecia. Previously this policy was titled Alopecia, Wigs, and Scalp Prosthesis.

Alopecia, Wigs, and Scalp Prosthesis *ARCHIVED*: This policy is archived effective December 1, 2017. Please refer to Alopecia Treatment medical policy effective December 1, 2017.

Autism Spectrum Disorders New York State: This medical policy applies only to MVP plans that are required to follow the New York State Health Insurance Law for applied behavior analysis for autism spectrum disorder treatment. Refer to the member's individual plan certificate for benefit coverage for applied behavioral analysis.

Applied behavior analysis is not covered for MVP Managed Care Medicaid Products.

Automatic External Defibrillators *NEW Policy*: Automatic External Defibrillators is a new policy effective December 1, 2017. The policy addresses both wearable

automatic defibrillators and non-wearable automatic defibrillators. There is both a Medicaid variation and a Medicare variation. Links to both the Medicaid and Medicare coverage criteria are listed in the policy.

Blepharoplasty, Brow Lift, and Ptosis Repair: There are no changes to the medical policy criteria.

Botulinum Toxin Treatment: There are no changes to the medical policy. Prior authorization is no longer required for CPT code 52287 effective January 1, 2017.

Breast Implantation: There are no changes to the medical policy criteria.

Breast Reconstruction Surgery: There are no changes to the medical policy criteria.

Clinical Guidelines Development, Implementation, and Review Process: There are no changes to the clinical guideline development, implementation, and review process.

Compression Stockings: There are no changes to the medical policy criteria. Compression stockings for Commercial products no longer require a disposable rider (effective immediately). For Medicaid products, gradient compression stockings are limited to two pairs twice per year for a total of four pairs per year.

Cranial Orthotics *NEW Policy*: Cranial Orthotics (e.g., helmet or cranial remodeling band) is a new policy effective December 1, 2017.

Erectile Dysfunction: There are no changes to the medical policy criteria.

Extracorporeal Shock Wave Therapy for Musculoskeletal Indications: There are no changes to the medical policy criteria. Extracorporeal Shock Wave Therapy has not been established in peer review literature to improve health outcomes in persons with musculoskeletal conditions. It is, therefore, considered not medically necessary.

Hearing Aid Services: There are no changes to the medical policy criteria. There is a Medicaid Managed Care variation with criteria for both monaural and binaural hearing aids.

Interspinous Process Decompression Systems (IPD): Interspinous Process Decompression Systems (IPD) are considered experimental and investigational and therefore are not covered. There is a Medicare variation that lists coverage criteria for the Interspinous Process Decompression System (X STOP®) for Medicare members when criteria are met. There is a Medicaid variation which states the Interspinous Process Decompression System (X STOP®) is not covered for Medicaid products.

Lymphedema–Pneumatic Compression Devices, Compression Garments, and Appliances: The following clarifying statement of coverage of segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) was added to the policy: "The only time that a segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) would be covered is when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a nonsegmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber." A variation was added for MVP Medicaid Managed Care products. Only the following HCPCS codes are covered for Medicaid: E0650, E0655, E0660, E0665, and E0666.

Orthotic Devices (other than therapeutic diabetic footwear): There are no changes to the medical policy criteria.

Penile Implant for Erectile Dysfunction: There are no changes to the medical policy criteria.

Prosthetic Devices (External) Eye and Facial and Scleral Shells: There are no changes to the medical policy criteria.

Prostatic Urethral Lift (PUL) System UroLift® *NEW Policy*: Prostatic Urethral Lift (PUL) System UroLift® is a new policy effective December 1, 2017. The Urolift® System has not been established in peer review literature to improve health outcomes. It is, therefore, considered not medically necessary for Medicare and Medicaid Products. There is a Medicare variation for prostatic urethral lift system (UroLift®). A prostatic urethral lift system is covered for Medicare members when the medical policy criteria is met.

Repetitive Transcranial Magnetic Stimulation (rTMS): There are no changes to the medical policy criteria.

Sinus Surgery–Endoscopic: There are no changes to the medical policy criteria.

Medical Policies Approved Without Changes in October 2017

Audiologic Screening and Evoked Otoacoustic Emissions (OAE)

Canaloplasty and Viscocanalostomy

Cardiac Procedures

Ground Ambulance Services and Ambulette Services

Intraoperative Neurophysiologic Monitoring During Spinal Surgery

Pharmacy Updates

Policy Updates Effective January 1, 2018

Proton Pump Inhibitor Therapy: Omeprazole/Sodium Bicarbonate removed as prerequisite drug. Prescription history or chart notes must substantiate trial of preferred agents Crohn's Disease and Ulcerative Colitis, Select Agents. Inflecta added to policy. Exclusion for more than one induction course added.

Irritable Bowel Syndrome *NEW Policy*: Prior authorization required for Xifaxan, Viberzi, and Lotronex. Viberzi moved to IBS policy.

Enteral Therapy New York: No changes.

Enteral Therapy Vermont: No changes.

Gaucher Disease Type 1: No changes.

Hereditary Angiodema: Ruconest dosing updated.

Chelating Agents: No changes.

Preventative Service-Medication: Added coverage of statins.

Spinraza *NEW Policy*

Topical Agents for Pruritus *NEW Policy*: Doxepin cream will require prior authorization.

Xifaxan: Criteria for IBS-D removed.

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
Haegarda	Hereditary Angioedema
Tremfya	Plaque Psoriasis
Nerlynx	Breast cancer
Vosevi	Hepatitis C
Idhifa	Leukemia
Mavyret	Hepatitis C
Besponsa	Leukemia
Mydayis	ADHD
Rituxan Hycela	Lymphoma/Leukemia
Benlysta	Lupus
Contempla	ADHD
Nityr	Hereditary tyrosinemia
Lynparza	Ovarian cancer
Armonair	Asthma
Vyxeos	Leukemia
Flolipid	Hyperlipidemia

Drugs Added to Formulary

Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace

Melphalan
Sevelamer tab
Testosterone TD Solution
Eletriptan
Moxifloxacin-tier 1 marketplace
Scopolamine Patch
Mesalamine Dr
Adaplene-Bebzoyl Peroxide
Prasugrel

Drugs Removed from Prior Authorization

Rubraca
Vemlidy
Ocrevus