HealthyPractices™

MVP HEALTH CARE

A Bi-Monthly Publication for MVP Health Care® Providers

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New York

In this Issue:

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

MVP Corporate Headquarters	**1-888-363-9485**
Southern Tier	**1-800-688-0379**
Central New York	**1-800-888-9635**
Midstate New York	**1-800-568-3668**
Mid-Hudson	**1-800-666-1762**
Buffalo/Rochester	**1-800-684-9286**

Denise V. Gonick
Chief Executive Officer
MVP Health Care, Inc.

We welcome your comments.

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PROFESSIONAL RELATIONS DEPT
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MVPPR0001 (10/2018)

Professional Relations Updates

Register for your secure provider web account to access claims information, member eligibility, benefits, authorizations, Gaps in Care reports (coming soon), and much more! To register, visit **mvphealthcare.com** and select *Providers*, then *Sign In/Register*, then *Register Now*.

Keep Your Online Demographics Up-to-Date

The new online form allows providers to communicate easily when they are changing or adding a new address, updating their Tax ID information, or even notifying MVP that a provider has left their group. Providers can submit the form electronically and will receive a reference number to check on the status of a change. This new process makes it easier to submit changes, saving you time to focus on patient care.

Please familiarize yourself with this form. MVP now requires all provider changes of information be submitted online[1]**.** To access the online form, visit **mvphealthcare.com/demographics**.

If you have any additional questions, please contact your MVP Professional Relations Representative.

[1]In some cases, a facility may still be required to provide a paper form. If you have any questions, please contact your Professional Relations Representative.

Caring for Older Adults

Testing and Treatment of Osteoporosis

Osteoporosis is a disabling condition that affects 55% of the American population aged 50 and older. This condition is primarily asymptomatic and often not diagnosed until after an initial fracture. According to the National Osteoporosis Foundation (NOF), one in two women age 50 or older will suffer an osteoporosis-related fracture in their lifetime. MVP has adopted the NOF guidelines, Prevention and Treatment of Osteoporosis. Key recommendations include:

- Bone Mineral Density (BMD) testing for women aged 65 and older. For post-menopausal women, testing should begin between age 50 and 69 if they have risk factors for the condition. BMD testing should be performed after a fracture to determine severity of the disease.
- Anyone with hip or vertebral fractures should be considered for treatment, as well as those with low bone mass according to their Dual-Energy X-ray Absorptiometry (DXA) score. FDA-approved treatments include biphosphonates, miscellaneous hormones (e.g. calcitonin) and estrogen/progesterone combinations.
- Calcium (>1,200 mg) and vitamin D (800–1,000 IU) should be taken daily by adults aged 50 and older, regardless of whether other medications to prevent or treat osteoporosis are prescribed. Despite the availability of specialized tests to detect

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Testing and Treatment of Osteoporosis *continued from page 1*

osteoporosis and medications to prevent it, the condition remains largely under-diagnosed and under-treated.

According to MVP's 2017 HEDIS results, only approximately 20% of women ages 67 or older received a BMD test or prescription for a medication to treat/prevent osteoporosis within the six months following a fracture.

Talk to Patients about Avoiding Hospital Readmission

To decrease readmission rates after a hospital stay, MVP is educating its Medicare Advantage plan members on how to be prepared for a smooth transition from hospital to home.

Well prepared members have a lower chance of having to be admitted back into the hospital because of a problem.

Providing continuity and coordination of care for a patient as they transition from the hospital setting to outpatient is also crucial in reducing hospital readmission rates. Health care providers can help by obtaining hospital discharge summaries promptly and documenting any changes in medical/surgical history and medications. Often, after a hospital stay, a patient may have additional specialists involved in their care. It is important for primary care providers (PCPs) and specialists to communicate relevant information to ensure a coordinated approach to the patient's care. It is also very important for the patient to see their physician within 3–7 days of discharge.

We encourage physicians to speak with MVP Medicare plan members about this important topic. Some helpful tips that members should follow include:

- Bring a complete list of medications to the hospital on the day of admission.
- Work with discharge planning staff to make a hospital follow-up plan.
- Take an active role in discharge and treatment planning.
- Learn any important details about the condition and how they can take care of themselves.
- Schedule a follow-up appointment within seven days after leaving the hospital.
- Bring hospital discharge plan along with a list of medications to follow-up appointment(s).
- Carry important information at all times about the condition, medications, doctor, and pharmacy contact information.

To help members keep important information with them at all times, MVP has created a handout with a checklist to be used for planning. To download the *Hospital-to-Home Planning*, visit **mvphealthcare.com** and select *Providers*, then *Quality Programs*, then *Provider Quality Improvement Manual*, then *Caring for Older Adults*, then *Useful Information for Patients*.

Utilization Management Updates

Financial Incentives Relating to Utilization Management

It is the policy of all of the operating subsidiaries of MVP Health Care, Inc. to facilitate the delivery of appropriate health care to our members, and to monitor the impact of the plan's Utilization Management (UM) Program to ensure appropriate use of services. The MVP UM Program does not provide financial incentives to employees, providers, or practitioners who make utilization management decisions that would encourage carriers to deny care and services.

MVP's utilization management decisions are based only on appropriateness of care and the benefits provisions of the member's coverage. MVP does not specifically reward practitioners, providers, or staff, including Medical Directors and UM staff, for issuing denials of requested care. MVP does not offer financial incentives, such as annual salary reviews and/or incentive payments to encourage inappropriate utilization.

Annual Notices for MVP Providers

As part of our commitment to the accreditation standards of the National Committee for Quality Assurance (NCQA), and to comply with state and federal government regulations, MVP publishes an annual summary of important information for practitioners and providers. This notice includes the following topics:

- MVP's recognition of members' rights and responsibilities
- Complaints and appeals processes
- Confidentiality and privacy policies, including measures taken by MVP to protect oral, written, and electronic PHI
- Medical management decisions
- Pharmacy benefit management
- Transition of patient care
- Emergency services
- Assessment of technology
- Medical record standards and guidelines

- Information about the MVP Quality Improvement Program
- Reporting suspected insurance fraud and abuse
- MVP's stance on physician self-treatment and treatment of immediate family members
- MVP's efforts to meet members' special, cultural, and linguistic needs

To access the *Annual Notices for MVP Health Care Providers*, visit **mvphealthcare.com** and select *Notice of Privacy Practices & Compliance* at the bottom of the homepage. If you would like to receive a printed copy of this information, please contact your MVP Professional Relations Representative.

Fraud, Waste, and Abuse

Detecting and Preventing Fraud, Waste, and Abuse (FWA)

MVP has policies and processes in place to detect and prevent fraud, waste, and abuse. These policies outline MVP's compliance with the False Claims Act and other applicable FWA laws and regulations. These laws and regulations prohibit MVP and its contractors from knowingly presenting or causing to present a false claim or record to the federal government, the State Medicaid program, or an agent of these entities for payment or approval. Contractors may access MVP's policy for Detecting and Preventing FWA online by visiting **mvphealthcare.com** and selecting *Providers*, then *Reference Library*, then *Learn about MVP Policies*. The MVP Special Investigations Unit (SIU) is instrumental in managing the program to detect, correct, and prevent FWA committed by providers, members, subcontractors, vendors, and employees. The SIU maintains a toll-free, 24-hour hotline at **1-877-835-5687**, where suspected fraud and abuse issues can be reported directly by internal and external sources.

Providing Compliance Training and Fraud, Waste, and Abuse Training

MVP's contractors who support its Medicare products and are first tier, downstream, or related entities are required to provide general compliance training and FWA training to their employees, subcontractors, and downstream entities. The Centers for Medicare & Medicaid Services (CMS) provides a Medicare Parts C and D FWA and general compliance training program. This online program is available through the CMS Medicare Learning Network. Entities who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of durable medical equipment, prosthetics/orthotics, and supplies are deemed to have met the FWA training requirement. However, these entities must provide general compliance training. To prevent and detect FWA, all MVP contractors should provide compliance and FWA training to their employees, subcontractors, and downstream entities upon hire, annually, and as changes are implemented.

Reporting Suspected Violations

MVP provides an Ethics and Integrity Hotline for reporting suspected violations of the Code or of its legal requirements. The Ethics and Integrity Hotline is available for employees, vendors, and contractors to report suspected violations anonymously by calling **1-888-357-2687**. EthicsPoint manages MVP's confidential reporting system and receives calls made to the hotline. EthicsPoint triages reports in a secure manner to MVP's Compliance Office. The Compliance Office promptly and thoroughly investigates all allegations of violations. All MVP contractors are required to report actual or suspected non-compliance and FWA that impacts MVP using the hotlines referenced above. Contractors are protected from intimidation and retaliation for good faith participation in the MVP Compliance Program.

The 2010 Amendment to the New York State HIV Testing Law Key Message

The 2010 Amendment to the New York State HIV Testing Law requires health care providers, including but not limited to, physicians, physician assistants, nurse practitioners, and nurse midwives who are providing primary care services, offer HIV testing to all persons ages 13–64 (or younger with risk factors). This must be done at least once and must be done more often if there is evidence of risky activity.

To access the guidelines, visit **mvphealthcare.com/PQIM** and select n *Infectious Disease* to view the clinical guidelines.

Clinical Guidelines for 2018

MVP has adopted Clinical Guidelines that address HEDIS measures. To access these guidelines, visit **mvphealthcare.com/PQIM**. At the bottom of the page you will find condition specific resources including Clinical Guidelines, Supporting Tools for Clinicians, and Useful Information for Patients.

In addition to the resources from MVP, the following condition specific resources are available:

Management of Ventricular Arrhythmias and Prevention of Sudden Cardiac Death

MVP, as part of its continuing Quality Improvement Program, has adopted the American College of Cardiology 2017 guideline for the Management of Ventricular Arrhythmias and Prevention of Sudden Cardiac Death (SCD). The guideline includes summary points from the American Heart Association (AHA)/American College of Cardiology (ACC)/ Heart Rhythm Society (HRS) Guideline for Management of Patients with Ventricular Arrhythmias (VAs) and the Prevention of SCD. Visit **acc.org** to review this guideline.

CHEST Guideline for Antithrombotic Therapy in Venous Thromboembolism

As part of its continuing Quality Improvement Program, MVP has adopted the CHEST Guideline for Antithrombotic Therapy in Venous Thromboembolism (VTE). The guideline contains 11 key points about this updated guideline document from the American College of Chest Physicians on antithrombotic therapy for VTE. Visit **acc.org** to review this guideline.

Annual Notice Regarding Domestic Violence Orders of Protection

The New York State Department of Financial Services recommends that providers print and post this notice in their office. The notice in PDF format is available in English and Spanish. To download the notice, visit **mvphealthcare.com** and select *Notice of Privacy Practices & Compliance* at the bottom of the homepage.

The Notice applies to members of health plans offered by the following MVP operating subsidiaries: MVP Health Plan, Inc. (except for Medicare Advantage products), MVP Health Services Corp., MVP Health Insurance Company, and Preferred Assurance Company, Inc.

Insurance Law § 2612 states that if any person covered by an insurance policy issued to another person who is the policyholder or if any person covered under a group policy delivers to the insurer that issued the policy, a valid order of protection against the policyholder or other person, then the insurer is prohibited for the duration of the order from disclosing to the policyholder or other person the address and phone number of the insured, or of any person or entity providing covered services to the insured. The regulation governs confidentiality protocols for domestic violence victims and endangered individuals.

To make a request, a requestor should contact the MVP Customer Care Center at the address or phone number indicated on the contact information on the notice.

The requestor must provide the MVP Customer Care Center with an alternative address, phone number, or another method of contact, and may be required to provide the MVP Customer Care Center with a valid order of protection.

To revoke a request, a requestor should submit a sworn statement to the address indicated on the contact information at the end of this notice. To contact the New York State Domestic Violence and Sexual Violence Hotline, call 1-800-942-6906.

Utilization Management Policy Guides for Prior Authorization Process and Requirements

The UM Policy Guides provides a quick reference of prior authorization requirements for all MVP health plans. The guide should be used in coordination with the Prior Authorization Request form (PARF). All services listed in these documents require prior authorization by MVP.

To view the complete *UM Policy Guides*, Sign In to your online account at **mvphealthcare.com** and select *Resources*, then *Other Resources*, them *UM Policy Guides*.

Quality Improvement Updates

MVP is Offering Gap Closure Incentives for Behavioral Health Measures

In today's current health care system, many patients continue to reach out to their PCP for all their medical needs, and this is also true for their mental health needs. Whether the PCP is the first to diagnose or has patients who feel more comfortable with their care versus a specialist, best practice is necessary to properly manage their care needs.

The following measures are representative of the care needed for both child/adolescent and adult patients with behavioral health issues.

Children/Adolescents with Behavioral Health Issues

If you see patients 6–12 years of age who are newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication, you need to have them seen again by a practitioner with prescribing authority within 30 days of the prescription dispensing date. To ensure further gap closure, you need to schedule two additional follow up visits, on different days, within the nine months of the initial visit noted

above. The patient must remain on the medication for at least 210 days and one of the two visits can be a phone visit.

If you see patients 1–17 years of age who are prescribed two or more concurrent antipsychotic medications, they need to have metabolic testing completed as of December 31 of the measurement year. Studies are showing an increase in antipsychotic prescribing over the last decades which then increases a child/adolescent's risk for serious health concerns such as weight gain, extrapyramidal side effects, and hyperprolactinemia. This is why the NCQA recommends metabolic testing for these children.

Adults with Behavioral Health Issues

If you see patients 18 years and older with a diagnosis of major depression and who are on antidepressant medication, you can close gaps in care by educating and verifying that your patients stay on their medications. The first gap closure is that they are on their medications for at least 84 days (12 weeks) and the second gap closure is if the patient continues past 84 days and stays on their medications for at least 180 days (six months). Remember, it's important for an insulin dependent diabetic to stay on their medication to prevent exacerbation of their diabetic status and the possible need for hospitalization. It is equally important for a patient with major depression to remain on their medication to prevent further deterioration of their illness.

If you see patients 18–64 years of age with a diagnosis of schizophrenia or bipolar disorder, and who are on antipsychotic medications, these patients should have diabetic testing by December 31 of the measurement year. Studies show a strong correlation between patients with schizophrenia or bipolar disorder and diabetes. Please ensure that they had either a glucose test or HbA1c test to evaluate their likelihood of developing diabetes. These patients may follow up with a mental health provider, but don't assume that this testing is done. Ask your patient, and if they don't know, get their permission to contact their mental health provider and verify testing.

For helpful tips about managing these behavioral health measures, please review the MVP HEDIS Reference Guides available at **mvphealthcare.com/HEDISTips**.

Early Intervention, Treatment, and Management of Substance Use Disorders

Early intervention services can be provided in a variety of settings (e.g., school clinics, primary care offices, mental health clinics) to people who have problematic use or mild substance use disorders. These services are usually provided when an individual presents for another medical condition or social service need and is not seeking treatment for a substance use disorder. The goals of early intervention are to reduce the harms associated with substance misuse, reduce risk behaviors before they lead to injury, improve health and social function, and to prevent progression to a disorder and subsequent need for specialty substance use disorder services. Early intervention consists of providing information about substance use risks, normal or safe levels of use, and strategies to quit or reduce the use and use-related risk behaviors, and facilitating patient initiation and engagement in treatment when needed. Early intervention services may be considered the bridge between prevention and treatment services. For individuals with more serious substance misuse, intervention in these settings can serve as a mechanism to engage them into treatment.

Early intervention should be provided to both adolescents and adults who are at risk of or show signs of substance misuse or a mild substance use disorder. One group typically in need of early intervention are people who binge drink—people who have consumed at least five (for men) or four (for women) drinks on a single occasion at least once in the past 30 days. Recent national survey data suggest that over 66 million individuals aged 12 or older can be classified as binge drinkers.

Available research shows that brief, early interventions given by a respected care provider, such as a nurse, nurse educator, or physician, in the context of usual medical care, (e.g., a routine medical exam or care for an injury or illness) can educate and motivate many individuals who are misusing substances to understand and acknowledge their risky behavior and to reduce their substance use.

Regardless of the substance, the first step to early intervention is screening to identify behaviors that put the individual at risk for harm or for developing a substance use disorder. Positive screening results should then be followed by brief advice or counseling tailored to the specific problems and interests of the individual and delivered in a non-judgmental manner, emphasizing both the importance of reducing substance use and the individual's ability to accomplish this goal. Later follow-up monitoring should assess whether the screening and brief interventions were effective in reducing the substance use below risky levels or whether the person needs formal treatment.

*Source: Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Chapter 4. Nov. 2016. .**ncbi.nlm.nih.gov/books/NBK424859***

Medicaid Updates

Health Home Program Announces New Recipient Restriction/Exception Codes

On July 16, 2018, two new Recipient Restriction/Exception (RR/E) codes went into effect for the Health Home Program. The purpose of these RR/E codes is to notify all Medicaid providers that these members are associated with the Health Home program.

A1 indicates the member is in outreach or enrolled with a Care Management Agency (CMA). **A2** indicates the member is in outreach or enrolled with a Health Home (HH).

Within ePACES, the actual A1/A2 codes are displayed within the "Medicaid Exceptions" field. This section does not include a description of the codes nor the member's CMA/HH provider information. The CMA/HH NPI and Provider name associated with the corresponding HH program A1/A2 code are displayed in the "Medicaid Restricted Recipient" field with the Service Category "CQ–Case Management". This does not indicate that the HH members are in the Restricted Recipient program (RRP). The codes do not restrict HH members to certain providers and does not limit the types of Medicaid services the member is eligible to receive. Members may change CMA/HH agencies, disenroll from the HH program, and may receive any other service(s) that they are entitled to.

Below is how a member in the HH program will appear within ePACES:

Medicaid Restricted Recipient:

Service Category	Provider
CQ – Case Management	
CQ – Case Management	

Medicaid Exceptions:

Exception Code
A1
A2
H1
H9

When a Medicaid Provider verifies eligibility using the Medicaid Eligibility Verification System and hears/sees the individual has these two codes, the provider should discuss the outreach or enrollment status in the HH program with the individual. If the individual indicates that they are not enrolled, the provider may discuss with them the benefits of the HH program and having a Care Manager. If the individual indicates they are enrolled in the HH program, the provider is encouraged to consent to communicate with the HH and/or CMA. This will allow the HH Care Manager and the provider to discuss the individual's care and needs. If the individual appears to be HH eligible and does not have either code on their eligibility return, a provider should refer the individual to the HH program. A provider may contact the individual's Medicaid Managed Care Plan to refer the individual into the HH program or may refer the member directly to a Health Home/Care Management Agency. For more HH eligibility and HH contact information, visit **health.ny.gov** and select *Individuals/Families*, then *Health Insurance Programs*, then *Medicaid*, then *Health Homes*.

Please note: Individuals enrolled in a PACE, FIDA, or FIDA-IDD Plan are excluded from enrollment in the HH program. However, individuals enrolled in either a mainstream or Managed Long-Term Care (MLTC) plan are eligible to enroll. HH and MLTC Managers must work together to ensure there are no duplication of services.

For additional information or questions, please contact the New York State Office of Health Insurance Programs, Health Home Policy Unit at **518-473-5569**.

Update to Physical Therapy Benefit for Medicaid Managed Care Members

Effective July 1, 2018, the Physical Therapy Benefit for Medicaid members has increased from 20 visits per calendar year to 40 visits per calendar year.

For additional updates to policies related to New York State Government programs, please refer to Section 12 of the MVP Provider Resource Manual (PRM).

Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during their September meeting. Some of the medical policies may reflect new technology while others clarify existing benefits. MVP 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 Benefit Interpretation Manual (BIM). To access the BIM, visit **mvphealthcare.com** and *Sign In* to your account, then select *Resources*, then *Benefits Interpretation Manual*. 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 April 1, 2018

Inhaled Nitric Oxide (INOmax): ***NEW POLICY*** Inhaled nitric oxide is covered for the following three indications when criteria outlined in the Indication/Criteria section of the policy: Hypoxic Respiratory Failure in Neonates, Postoperative Management of Pulmonary Hypertension following repair of Congenital Heart Disease, and Assessing Pulmonary Vaso-reactivity in Persons with Pulmonary Hypertension.

Joint Replacement and Implant for Hallux Rigidus: ***NEW POLICY*** Total prosthetic replacement arthroplasty with only silastic implants when policy criteria are met. Metatarsal implants, modular implants, interposition arthroplasty with biologic spacers, and metatasophalangeal synthetic cartilage implants are all considered experimental and investigational and therefor are not covered.

Leadless Cardiac Pacemakers: ***NEW POLICY*** Leadless cardiac pacemakers are considered experimental and investigational and therefor are not covered for Commercial products. Leadless cardiac pacemakers are not covered for MVP Medicaid Managed Care products. There is a Medicare variation. Leadless cardiac pacemakers are covered for Medicare members through Coverage with Evidence Development (CED) as outline within the medical policy.

Transcatheter Closure of Patent Foramen Ovale: ***NEW POLICY*** A transcatheter patent foramen ovale (PFO) occluder (Amplatzer PFO Occluder) is covered when the policy criteria is met as outlined in the Indication/ Criteria section of the policy. There are two other Amplatzer devices: the Amplatzer Cardiac Plug (APC) and the Amplatzer Vascular Plug. Both of these devices are considered experimental and investigational and therefor are not covered.

Medical Policies Reviewed and Approved in 2017 for Approval Without Changes in 2018

Emergency Department Services

Mental Health Services

Phototherapeutic Keratectomy/Refractive Surgery

Power Mobility Devices

Speech Therapy (Outpatient) & Cognitive Rehabilitation

Medical Policy Updates Effective June 1, 2018

Cold Therapy Devices: There are no changes to the medical policy criteria or indications.

Continuous Passive Motion Devices: There are no changes to the medical policy criteria or indications.

Compression Stockings: Custom compression stocking/ garments (CPT code A6549) is covered. This is listed in the MVP Medicaid Managed Care, MVP Child Health Plus Variation section of the policy.

Cell-Free Fetal DNA-Based Prenatal Screening for Fetal Aneuploidy: There are no changes to the medical policy criteria or indications.

Emergency Department Services: There are no changes to the medical policy criteria or indications.

Gene Expression Classifier (Afirma®): ***ARCHIVED*** This policy was archived effective June 1, 2018. Please refer to Molecular Markers in Fine Needle Aspirates of the Thyroid (Afirma®), (RosettaGX Reveal™), (Thyramir), (ThyGenX) oncogene mutational panel medical policy effective June 1, 2018.

Hyperbaric Oxygen Therapy (HBO): HCPCS Code E0446 is listed in the Medicare Variation section of the medical policy.

Imaging Procedures: Computed Tomographic (CT) colonography screening is covered when all the medical policy criteria listed are met for all products except Medicare. CT colonography is not reimbursable when used in the absence of signs or symptoms of disease, regardless of family history or other risk factors for the development of colonic disease, and is not covered for Medicare. Refer to the Medicare Variation section of the medical policy. Thermography (93740).

Molecular Markers in Fine Needle Aspirates of the Thyroid (Afirma®) (RosettaGX eveal™) (ThyraMIR) (ThyGenX) Oncogene Mmutational Panel: ***NEW POLICY*** Gene expression classifier (Afirma®) for thyroid follicular neoplasm, Hürthle cell neoplasm, atypia of undetermined significance (AUS) or follicular lesion of undetermined significance (FLUS) is considered medically necessary. This is listed under the Indications/Criteria section of the policy. Thyroid microRNA Expression Classifier (Rosetta(GX Reveal™) is considered experimental/investigational. ThyraMIR is considered experimental/investigational, (ThyGenX) oncogene mutational panel is considered experimental/ investigational. The ThyroSeq v2 test is considered experimental/investigational. The aforementioned are listed under the Exclusion section of the medical policy.

Phototherapeutic Keratectomy and Refractive Surgery: There are no changes to the medical policy criteria or indications.

Power Mobility Devices: An add-on to convert a manual wheelchair to a joystick-controlled power mobility device (E0983) or **to a tiller controlled power mobility device (E0984) will be denied as not reasonable and necessary**. The bolded text was added to this indication. This is located in the Exclusion section of the medical policy. There are language updates which were made to clarify the wording of the medical policy.

Policies Reviewed and Approved in 2017 for Approval without Changes in 2018

Allergy Testing and Allergen Immunotherapy

Chiropractic Care

Colorectal Cancer Genetic Testing

Custodial Care

Dental Care Services Facility Services

Dental Care Services Medical Complications of Dental Problems

Dental Care Services Prophylactic Dental Extractions

Epidermal Nerve Fiber Density Testing

Genetic Counseling and Testing

Hospital Inpatient Level of Care

Obstructive Sleep Apnea: Treatment

Scoliosis Bracing

Speech Generating Devices

Ventricular Assist Device: Left

Vertebroplasty and Vertebral Augmentation (Percutaneous)

Medical Policy Updates Effective August 1, 2018

Audiologic Screening and Evoked Otoacoustic Emissions (OAE): There are no changes to the medical policy criteria or indications.

Breast Pumps: There are no changes to the medical policy criteria or indications.

Cardiac Procedures: Clarification regarding MVP's stance on the Watchman device was added to the policy. Watchman and Lariat are both considered investigational. This is covered when the member is participating in a clinical study for Medicare members only.

Gas Permeable Scleral Contact Lens (e.g., BostonSight® Ocular Surface Prosthesis): There are no changes to the medical policy criteria or indications.

Ground Ambulance and Ambulette Services: Language was added to the policy clarifying that for Medicare members, paramedic intercept is denied administratively, not medically.

Idiopathic Scoliosis Surgery and Growing Rods Technique: ***NEW POLICY*** Traditional or magnetically (e.g., MAGEC® magnetic growth rod) controlled growing rod technique is considered medically necessary when the criteria outlined in the policy are met.

Immunizations Childhood, Adolescent, and Adult: CPT Code 90634 for Hepatitis-A vaccine, pediatric/adolescent dose and CPT Code 90750 for Shingrix vaccine were added to the policy as covered codes.

Personal Care and Consumer Directed Services for MVP Medicaid Managed Care Members: Language changes were made to the policy to reflect language changes in regulations governing the policy.

Policies Reviewed and Approved in 2017 for Approval without Changes in 2018

Medical Policy Development, Implementation, and Review Process

Temporomandibular Joint Dysfunction (TMJ) NY

Temporomandibular Joint Dysfunction (TMJ) VT

Transcatheter Aortic Valve Replacement

Vision Therapy (Orthoptics, Eye Exercises)

Pharmacy Updates

Policy Updates Effective October 1, 2018

Cialis for BPH: No changes

Agents for Hypertriglyceridemia: No changes

Gout Treatments: Added Duzallo

Pain Medications:

- Added Xtampza
- Added Morphabond ER

Inflammatory Biologic Drug Therapy:

- Added Kevzara
- Added Taltz
- Added new indication for Xeljanz
- Clarified adalimumab once weekly dosing

Methotrexate Autoinjector: No changes

Pulmonary Hypertension (Advanced Agents): Added Revatio suspension

Epinephrine Autoinjector: No changes

Migraine Agents: No changes

Nuedexta: ***NEW POLICY***

Medicare Part D Transition Supply Policy and Procedure: Updated per CVS Caremark Medicare Part D 2019 updates

Luxturna: ***NEW POLICY***

Duchenne Muscular Dystrophy: Added Exondys 51

Orphan Drug(s) and Biologics:

- Added Brineura
- Added Mepsevii

Policy Updates Effective December 1, 2018

Irritable Bowel Syndrome:

- Added exclusion for Xifaxan to treat small intestinal bacterial overgrowth Xifaxan
- Added exclusion for Xifaxan to treat small intestinal bacterial overgrowth Enteral Therapy New York
- Added exclusion for enzyme cartridges

Enteral Therapy Vermont:

- Added exclusion for enzyme cartridges

Hereditary Angioedema: No changes

Proton Pump Inhibitor Therapy:

- Added OTC Zegerid (generic) and OTC esomeprazole as Medicaid formulary agents
- Added exclusion for esomeprazole strontium

Gaucher Disease Type 1 Treatment:

- Added miglustat PCSK9 Inhibitors
- Updated to include new indication of primary hyperlipidemia for Repatha

Lyme Disease/IV Antibiotic Treatment:

- Clarified that prior authorization is only required when used to treat Lyme disease

Preventative Services—Medications:

- Removed Vitamin D (effective December 31, 2018)

Hemophilia Factor

- Updated Jcodes
- Added Hemlibra

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	Indicator
Admelog	Diabetes
Olumiant	Rheumatoid Arthritis
Roxybond	Pain
Eskata *(medical benefit)*	Seborrheic Keratosis
Siklos	Sickle Cell
Imvexxy	Dyspareunia
Tibsovo	AML
Orilissa	Pain associated with endometriosis
Lokelma	Hyperkalemia
Plenvu	Colonoscopy prep
Symtuza	HIV
Macrilen *(medical benefit)*	Diagnosis of adult growth hormone deficiency
Zemdri	Complicated UTI
Braftovi	Metastatic Melanoma
Mektovi	Metastatic Melanoma
Fulphila	Decrease incidence of infection in patients receiving myelosuppressive anti-cancer drugs
Kapspargo	Hypertension

Drugs Added to Formulary

Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace

Budesonide 9mg *(Non-Formulary for Medicaid)*
Crotamiton lotion
Desoximetasone spray 0.25% *(Non-Formulary for Medicaid)*
Dorzolamide/timolol PF

Drugs Removed from Prior Authorization

Biktarvy
Juluca
Ozempic
Prevymis tablets
Sinuva *(medical benefit)*
Sublocade *(medical benefit)*

Drugs Excluded from the Formulary Effective November 1, 2018

Kristalose
Vexasyn gel

Drugs Excluded from the Formulary Effective January 1, 2019

Anusol HC/Hemomorex HC suppository
Belladonna/opium suppository
Belladona alkaloids
Cifrazol
Donnatol
Metoclopramide ODT
Nascobal
Nicadan
Ortho D
Ortho DF
Phenohytro
Tronvite

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