

2016-2017



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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

MVP Corporate Headquarters	1-888-363-9485
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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

President & CEO
MVP Health Care, Inc.

We welcome your comments.

HEALTHY PRACTICES
MVP HEALTH CARE
PROFESSIONAL RELATIONS DEPT
PO BOX 2207
SCHENECTADY NY 12301



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 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*,

(Continued on page 2)

(*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**.

Toll-Free Provider Consult Line

For our New York practitioners, Beacon Health Options offers a toll-free Provider Consult Line staffed by Board Certified Psychiatrists. These psychiatrists are available for telephonic consultation regarding all aspects of mental health and substance abuse treatment for children and adults, including appropriate use of psychotropic medications. PCPs as well as Specialists may call the Beacon Provider Consult Line for consultation at **1-877-241-5575**, Monday–Friday, 9 am–6 pm Eastern Time.

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.

Medicaid Program Updates

Improving Perinatal Care for Medicaid Members

As part of the MVP Health Care 2017-2018 Performance Improvement Project (PIP) for the New York State Department of Health, MVP will be working with OB/GYN providers to improve perinatal care for its Medicaid members. One of the goals is to improve utilization of Long-Acting Reversible Contraception (LARC) to support birth spacing that is optimal for maternal-fetal outcomes and patient choice.

Rapid repeat pregnancy (within 12–18 months following delivery) is possible if women unsuccessfully initiate or inconsistently use short-acting contraceptive methods after delivery. Brief inter-pregnancy intervals have been associated with an increased risk for several poor maternal and infant health outcomes, including preterm birth, low birth weight, and perinatal death. In addition, births that are unintended are not only at increased risk for adverse maternal and infant health outcomes, but are associated with other risks such as smoking and delayed prenatal care.

Long-Acting Reversible Contraception (LARC) has been shown to be an effective method of birth control with little effort required on the part of the individual after insertion. Several professional organizations publish recommendations on the use of LARC, including the American Congress of Obstetrics and Gynecology, the

American Academy of Pediatrics, and the Centers for Disease Control and Prevention. Recommendations generally include:

- Providing counseling on all contraceptive options for all women at risk of unintended pregnancy.
- Encouraging use of LARC for all appropriate candidates, including nulliparous women and teens.
- Adopting best practices for LARC insertion, including provision on the same day as requested, and at the time of delivery, miscarriage, or abortion.

Preliminary results from one of four cohorts reported in the New York State Department of Health's Medicaid Prenatal Care Quality Improvement Project tool indicated that only 11.4% of women received contraception immediately post-delivery. MVP will endeavor to increase the percentage of women ages 15–44 who are provided with LARC within three to 60 days post-delivery.

MVP has several tools available to support providers in achieving this goal. For more information visit **mvphealthcare.com** and select *Providers*, then *Quality Programs*, then *Provider Quality Improvement Manual* and view the *Women's Health* section.

Action required by December 1, 2017: Enroll with New York State Medicaid Programs

Effective January 1, 2018, Federal law requires that all Medicaid Managed Care and Children's Health Insurance Program (Child Health Plus) network providers be enrolled with New York State Medicaid programs. We are communicating how this requirement impacts providers and what steps need to be taken due to this regulatory change. The Medicaid provider enrollment process is to ensure appropriate and consistent screening of providers and to improve program integrity.

It's important for all providers to understand that applications must be received by CSRA, the Medicaid fiscal agent, by December 1, 2017.

New York State now requires that providers enroll as a Medicaid provider or you may be removed from the MVP Health Plan Medicaid Managed Care provider network. This new requirement to enroll as a Medicaid provider does not require providers to accept Medicaid fee-for-service patients.

Options for Enrollment

- If at one time you were a Medicaid provider, and your enrollment has lapsed (no longer actively enrolled), you

may be able to keep your original Provider Identification Number (PID), also known as MMIS ID, by indicating Reinstatement on the application.

- Practitioners may either enroll as a non-billing, Ordering/Prescribing/Referring/Attending (OPRA) provider, or as a Medicaid billing provider.
- Business, Group Practice, and Institutional provider types will be offered the option to enroll in Medicaid as a billing or non-billing (Managed Care Only) provider.

To enroll, providers will need to complete paperwork and submit it to New York State Medicaid. Please visit **emedny.org** and select *Provider Enrollment*, then navigate to your provider type to print and review the Instructions and the Enrollment form. At this website, you will also find a *Provider Enrollment Guide*, a *How Do I Do It? Resource Guide*, *FAQs*, and all the necessary forms related to enrollment in New York State Medicaid.

If you have questions during the New York State Medicaid Enrollment process, please contact the eMedNY Call Center at **1-800-343-9000**.

If you have any additional questions, please contact your MVP Professional Relations Representative or the MVP Provider Call Center at **1-800-684-9286**.

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

Guidelines for the Testing, Management, and Treatment of HIV/AIDS

As part of a continuing Quality Improvement Program, MVP has adopted the New York State Department of Health's (NYSDOH) AIDS Institute's recommendations for the prevention and management of HIV infection in adults, children, and adolescents, and the prevention of HIV transmission during the perinatal period.

The HIV/AIDS Guideline document contains an overview of testing, management, and treatment of HIV from different professional and regulatory organizations such as the NYSDOH and the American Congress of Obstetricians and Gynecologists (ACOG). There may be differences in recommendations regarding HIV testing among the organizations. Providers in New York State must follow the New York State requirements at a minimum.

The HIV/AIDS Guideline document lists several professional organization's guidelines documents which include:

- NYSDOH's AIDS Institute
- American Congress of Obstetricians and Gynecologists
- Primary Care Approach to the HIV-Infected Patient
- The NYSDOH HIV Testing During Pregnancy and Delivery Guideline
- The American Congress of Obstetricians and Gynecologists. Committee Opinion: Prenatal and

Perinatal Human Immunodeficiency Virus Testing:
Expanded Recommendations

- Centers for Disease Control MMWR Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings

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, to 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 risk activity.

To access the guidelines, visit mvphealthcare.com and select *Providers*, then *Quality Programs*, then *Provider Quality Improvement Manual* and view the Infectious Disease section for Clinical Guidelines.

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

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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**.

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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.

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- 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***(Continued on page 2)*

Mid-Hudson New York

MidHudsonprdept@mvphealthcare.com

Vermont

vpr@mvphealthcare.com

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

Caring for Older Adults

Talk to Your MVP Medicare Patients About Physical Activity

Each year the Centers for Medicare and Medicaid Services (CMS) Health Outcomes Survey is sent to a sampling of Medicare health plan members. To improve their overall health, these members are asked, “In the past 12 months, has your health care doctor or other provider advised you to start, increase, or maintain your level of exercise or physical activity?” In addition, a provider may also advise members to start taking the stairs, increase walking 10–20 minutes every day, or maintain a current exercise program.

These questions will measure the Medicare Advantage Plan provider’s involvement in monitoring the physical activity of their patients. The results are included in the annual CMS Star Ratings. Approximately 52% of the MVP Medicare members have responded that these discussions occur with their doctor. This is significantly lower than national results.

Daily physical activity can reduce depression, anxiety, and promote a sense of general well-being. Even patients that have not been active for years may take this advice when it comes from you! It is important to discuss physical activity with your patients at each visit to ensure that they get responsible clinical advice on the appropriate level of exercise.

In March 2017, members were sent a brochure, *Take Steps Toward a Healthier You*. We have placed a PDF of the brochure on our website for your reference. This may help to begin the discussion about physical activity and other topics included within the document. To view or download the brochure, visit **mvphealthcare.com** and select *Providers*, then *Quality Programs*, then *Provider Quality Improvement Manual*, then *Caring for Older Adults*, then *Useful Information for Patients*, then *Take Steps Toward a Healthier You—Wellness tips and support from MVP*.

Quality Improvement Updates

2017 HEDIS Coding Reference Guides

MVP has created reference guidelines to provide you and your staff with tools that explain the HEDIS measures, as well as provide the CPT, HCPCS, and ICD-10 codes that count towards the completion of these measures.

To access the 2017 HEDIS Coding Reference Guides, visit **mvphealthcare.com** and select *Providers*, then *Quality Programs*.

To access the ICD-10 Resources, visit **mvphealthcare.com** and select *Providers*, then *Reference Library*, then *ICD-10 Updates and FAQs*.

Preventing Preterm Birth with Makena®

A history of preterm birth is one of the strongest clinical risk factors for recurrent preterm birth. It is reported to confer a 1.5 to 2-fold increased risk of preterm birth in a subsequent pregnancy¹. Preventing recurrent preterm births among women with a history of preterm birth, and the use of 17P (17 alpha-hydroxyprogesterone), a clinical intervention, are cited in the Prevention Agenda action plan for reducing preterm births².

The American Congress of Obstetricians and Gynecologists (ACOG) Practice Bulletin, “Prediction and Prevention of Preterm Birth,” recommends that a woman with a singleton gestation and a prior spontaneous preterm singleton birth should be offered progesterone supplementation, regardless of transvaginal ultrasound cervical length, to reduce the risk of recurrent spontaneous preterm birth (Grade A Recommendation)³. Makena (hydroxyprogesterone caproate) is approved by the Federal Drug Administration for the prevention of recurrent preterm birth, with initiation of therapy between 16 weeks, 0 days, and 20 weeks, six days of gestation and weekly intramuscular injections continuing through 36 weeks and six days of gestation or delivery, whichever is earlier.

Data from the New York State Department of Health’s Medicaid Prenatal Care Quality Improvement Project, a statewide obstetric practice based self-evaluation project implemented in 2014, showed that 9.8% of women in the study sample of women with a delivery in 2013 had a history of a preterm birth documented. Of these women, 59.5% had a prior spontaneous preterm birth, but among those who were eligible for 17P, only 20.7% received the intervention.

MVP Health Care would like every pregnant woman to deliver a healthy baby at term. For some pregnant

women, Makena may be their best opportunity to deliver at term. Timely initiation of Makena injections is important. Common barriers to the initiation of Makena include failure to offer Makena to eligible women, patient refusal of treatment, and late entry into prenatal care. Continuation of weekly Makena injections is also important. If you have patients who have difficulty keeping appointments, MVP can provide Care Management support to facilitate continuity of care. If you have pregnant patients who would benefit from MVP Care Management support to maintain timely Makena injections, please call **1-866-942-7966**.

¹ American College of Obstetricians and Gynecologists. Practice Bulletin Number 130. Prediction and Prevention of Preterm Birth. Obstetric Gynecology 2012; 120(4):964-973.

² New York State Department of Health. Prevention Agenda 2013-2017: New York State's Health Improvement Plan. Available at health.ny.gov/prevention/prevention_agenda/2013-2017/plan/wic/focus_area_1.htm#g1.2. Last accessed November 21, 2016.

³ American College of Obstetricians and Gynecologists. Practice Bulletin Number 130. Prediction and Prevention of Preterm Birth. Obstetric Gynecology 2012; 120(4):964-973.

Integrating Behavioral Health and Primary Care

Behavioral health conditions are extremely common, affecting nearly one of five Americans and leading to health care costs on par with cancer. Conditions like depression can be disruptive, occurring among Americans of all ages and leading to significant disability and lost income. In spite of this, behavioral health care is mostly separated from the primary care system—a practice that the Institute of Medicine concluded nearly 20 years ago was leading to inferior care. In the intervening years, evidence has continued to mount that having two mostly independent systems of care leads to worse health outcomes and higher total spending. This is particularly true for patients with comorbid physical and behavioral health conditions ranging from depression and anxiety, which often accompany physical health conditions, substance abuse, and more serious and persistent mental illnesses.

Part of the issue is that the majority of patients with behavioral health problems—as many as 80%—only utilize emergency departments and primary care clinics, where providers often lack the time, training, and staff resources to recognize and treat behavioral health conditions. By some estimates, 60–70% of these patients leave medical settings without receiving treatment for behavioral health conditions even though this increases the odds that

they will have difficulty recovering from their medical conditions. Some patients do enter the behavioral health system, where the vast majority of clinical social workers, psychologists, and psychiatrists work at independent practices, clinics, and hospitals that treat mental health and substance abuse problems exclusively. But many patients referred for behavioral health treatment do not follow through, adding to the cohort of patients who receive no care.

Failure to recognize and appropriately treat behavioral health conditions has a significant impact on health outcomes and costs. Patients with these diagnoses use more medical resources, are more likely to be hospitalized for medical conditions, and are readmitted to the hospital more frequently. Some of these patterns are reflected in an analysis commissioned by the American Psychiatric Association (APA). The analysis found that costs for patients with comorbid mental health or substance abuse problems is 2.5–3.5 times higher than for those without such problems, with the vast majority of spending going to general medical services, and not behavioral health. For example, almost half of those who die from tobacco-related illnesses also have a serious mental illness, according to Paul Summergrad, M.D., the APA's president, though those with serious mental illnesses make up only 6% of the U.S. population.

Barriers to Integration

This evidence, combined with the growing recognition that physical, mental, and social challenges are interrelated, has led to calls to integrate behavioral health care and primary care services.

Some of the more well-tested models for integrating behavioral health services into primary care focus on training primary care providers to use evidence-based practices in screening and treating depression, anxiety, and other conditions that can be effectively managed in primary care settings. These models often also include a care manager or behavioral health specialist who follows up with patients, and monitors their response and adherence to treatment. Other models focus on integrating primary care services into behavioral health clinics. This promotes better access for patients who regularly receive care in these clinics, as well as improved care coordination for their medical needs. The main goal of most of the integrated care programs is to improve communication between behavioral health and primary care providers and thereby improve care coordination.

In addition, integration requires both primary care and behavioral health providers to change the way they work. Primary care providers—pressed for time and burdened with multiple priorities—often prefer to refer patients with mental or substance abuse problems to specialists, while behavioral health providers may be hesitant to practice in primary care settings, in part because it requires a new skill set, according to Michael Hogan, Ph.D., former Commissioner of Mental Health for New York State and former Chair of George W. Bush’s President’s Commission on Mental Health. “As part of a team, behavioral health providers have to deal not only with depression and anxiety but also heart failure and diabetes,” he says. In similar fashion, primary care providers must be comfortable talking about behavioral health issues, particularly substance abuse.

Many of the health care organizations that have made progress in integrating behavioral health and primary care have either funded the initiatives themselves or relied on grants. Others have taken advantage of Medicare and Medicaid demonstration programs and waivers that enable them to accept global payments for delivering both types of services. Some larger health systems have been willing, at least in the short run, to absorb the costs of adding behavioral health services to primary care. This is assuming that the investment potentially helps them to succeed in future value-based contracts by allowing them to share in any savings that accrue from improved outcomes and reduced costs.

While there are still significant barriers to integrating behavioral health and primary care, there are also several forces encouraging it, among them: new payment policies, including models that begin to hold providers accountable for controlling overall costs, and demonstration programs led by Medicaid and Medicare. Mental health parity laws that prevent insurers from placing greater financial requirements (e.g., co-payments) or treatment restrictions on mental health or substance abuse care than they do on medical care also help, as does the fact that private health plans sold through the Affordable Care Act’s health marketplaces must now include behavioral health benefits. Convenience for patients and their desire to avoid the stigma still attached to separate psychiatric care are also factors. “All of this is creating a perfect storm of encouraging integration,” says Hogan.

Adapted from “In Focus: Integrating Behavioral Health and Primary Care”. By Sarah Klein and Martha Hostetter, August/September, 2014 issue.

Medicaid Program Updates

Attention Medicaid Managed Care and Child Health Plus Providers: Medicaid Fee-for-Service Provider Enrollment Requirement Effective January 1, 2018

Section 5005(b)(2) of the 21st Century Cures Act amended Section 1932(d) of the Social Security Act (SSA) and requires that effective January 1, 2018, all Medicaid Managed Care and Children’s Health Insurance Programs (Child Health Plus) will require providers to enroll with state Medicaid programs. The SSA requires that the enrollment will include providing identifying information including: Name, Specialty, Date of Birth, Social Security Number, National Provider Identifier (NPI), Federal Taxpayer Identification Number, and the State License or Certification Number.

For example, if a physician currently participates in a network with a Medicaid Managed Care plan that provides services to, or orders, prescribes, or certifies eligibility for services for individuals who are eligible for medical assistance, the physician must enroll with New York State Medicaid.

Answers to Common Enrollment Questions

- To check on your enrollment status, please call CSRA at **1-800-343-9000**. Practitioners may also check the Enrolled Practitioners Search function by visiting **emedny.org** and selecting *Information*, then *Enrolled Practitioners SEARCH*.
- If you are already enrolled as a Medicaid fee-for-service (FFS) provider and are listed as active, you will not have to enroll again.
- If you were a Medicaid FFS provider and your enrollment has lapsed (no longer actively enrolled), you may be able to keep your original Provider Identification Number (PID), also known as MMIS ID, by reinstating.
- Practitioners who do not wish to enroll as a Medicaid FFS billing provider may enroll as a non-billing, Ordering/Prescribing/Referring/Attending (OPRA) provider.
- Enrollment in Medicaid FFS does not require providers to accept Medicaid FFS patients.

If you are not actively enrolled, visit **emedny.org** and select *Provider Enrollment*, then navigate to your provider type. Print the Instructions and the Enrollment form. On this website, you will also find a Provider Enrollment Guide, a

How Do I Do It? Resource Guide, FAQs, and all forms related to enrollment in New York State Medicaid.

This information appeared on page 6 of the New York State Department of Health's May 2017 edition of the Medicaid Update.

MVP Health Home Program

A Health Home is a group of health care and service providers working together to make sure individuals get the care and services they need to stay healthy, and reduce hospital and emergency room visits. To further assist providers in engaging with a Health Home in which your member may be enrolled, we have added additional information on the MVP Provider Portal to help you gain access to the member's Health Home Care Manager. Visit **mvphealthcare.com** and *Sign In* to your account, then search member information under *Eligibility and Benefits*.

The MVP Provider Portal can also assist hospitals with New York State's recent Hospital Requirement for making referrals to Health Home. To find these new requirements, visit **health.ny.gov**.

A Health Home Care Manager can assist providers by helping connect members to appointments such as their medical visits, follow up visits, and lab work, as well as helping members access other care needs such as behavioral health and social services.

If you would like to refer a member who is not enrolled in a Health Home, or if you have any questions about the Health Home program, please email **healthhome@mvphealthcare.com**.

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 October 1, 2017

Alopecia Treatment New Policy: Alopecia Treatment is a new policy effective October 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 October 1, 2017. Please refer to Alopecia Treatment medical policy effective October 1, 2017.

Autism Spectrum Disorders in 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 Medicaid Managed Care products.

Automatic External Defibrillators New Policy:

Automatic External Defibrillators is a new policy effective October 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.

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.

Lenses for Medical Conditions of the Eye: There are no changes to the medical policy criteria.

Lymphedema—Pneumatic Compression Devices, Compression Garments, and Appliances: The following clarifying statement of coverage a 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 non-segmented 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.

Oncotype DX™ Test: There are no changes to the medical policy criteria.

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.

Prostatic Urethral Lift (PUL) System UroLift® New Policy: 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.

Scoliosis Bracing: There are no changes to the medical policy criteria.

Clinical Guidelines Approved by the Quality Improvement Committee in September 2017

Guidelines for the Testing, Management, and Treatment of HIV/AIDS

New York State Department of Health’s (NYSDOH) AIDS Institute’s recommendations for the prevention and management of HIV infection in adults, children, adolescents, and the prevention of HIV transmission during the perinatal period. In addition, MVP reviews and utilizes guidelines from the Centers for Disease Control (CDC).

MVP also provides an overview of testing, management, and treatment of HIV from different professional and regulatory organizations such as the New York State NYSDOH, and the American Congress of Obstetricians and Gynecologists (ACOG). There may be differences in recommendations regarding HIV testing among the organizations. Providers in New York State must follow the New York State requirements at a minimum.

Pharmacy Updates

Hemophilia Factor—Medicaid

Effective July 1, 2017, Hemophilia Factor products are a covered benefit for MVP Medicaid members and will no longer be covered by New York Medicaid fee-for-service. Prior authorization is not required for these products, but providers must complete and submit a Prior Notification form. To download the form, visit mvphealthcare.com and select *Providers*, then *Forms*, then *Prior Authorization*. The vendor supplying the factor product will also be required to complete and submit a quarterly vendor report.

Policy Updates Effective October 1, 2017

Cialis for BPH: Exclusion added to clarify that fills are limited to a 30-day supply.

Agents for Hypertriglyceridemia: Criteria for omega-3 acid ester capsules updated and will now require triglyceride level greater than or equal to 500mg/dL and failure of three month trial of fish oil capsules. Criteria for Lovaza and Vascepa updated and will now require failure of a three month trial of omega-3 acid ester capsules.

PCSK9 Inhibitors: No changes.

Gout Treatments: Criteria for Zurampic added.

Arthritis, Inflammatory Biologic Drug Therapy: Name of policy changed and will now be called Inflammatory Biologic Drug Therapy.

- Inflectra added to policy
- Criteria for Humira used for the treatment of Uveitis added
- Criteria for Actemra used to treat Giant Cell Arteritis added
- Orencia added to the agents used for the treatment of psoriatic arthritis

Methotrexate Autoinjector: No changes.

Migraine Agents: Onzetra and Zembrace added to policy. Quantity limit for Sumavel updated to six injections per month.

Pulmonary Hypertension (Advanced Agents): Criteria for Uptravi added to policy.

Quantity Limits for Prescription Drugs: The following quantity limits were added: Santy ointment-30 gm per 30 days, Breo Ellipta-1 inhaler per 23 days (Medicaid only), Tamiflu suspension-180ml per 180 days.

Orphan Drug(s) and Biologicals: The following drugs were added: Kanuma, Impavido, Korlym, Orfadin, Xuriden and Zolanza.

Transgender Policy (Medicaid Only): Age limit updated to 16 years and older.

Hemophilia Factor: For Medicaid members only, provider must complete Prior Notification form and vendors supplying factor product must submit quarterly vendor summary reports.

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
Austedo	Chorea associated with Huntington’s disease
Zejula	Ovarian, fallopian tube and primary peritoneal cancer
Ingrezza	Tardive dyskinesia
Alunbrig	NSCLC
Rydapt	AML
Tymlos	Osteoporosis

Drug Name	Indication
Xadago	Parkinson’s disease
Brineura	CLN2
Imfinzi	Metastatic urothelial carcinoma
Radicava	ALS
Kevzara	Rheumatoid arthritis
Intrarosa	Moderate to severe dyspareunia
Siliq	Moderate to severe Plaque psoriasis
Morphabond	Severe pain
Syndros	N/V due to chemotherapy

Drugs Added to Formulary
Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace
 Rivelsa
 Tazarotene cream 0.1%
 Atomoxetine-QL of 90 per 30-day
 Ezetimibe-simvastatin
 Buprenorphine TD patch
 Sevelamer packets
 Olopatadine 0.2% oph drops-Tier 1 for Marketplace

Drugs Removed from Prior Authorization

Royaldee	Taytulla
Kyleena	Lartruvo
Vemlidy	Adlyxin
Soliqua	Basaglar



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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

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

President & CEO
MVP Health Care, Inc.

We welcome your comments.

HEALTHY PRACTICES
MVP HEALTH CARE
PROFESSIONAL RELATIONS DEPT
PO BOX 2207
SCHENECTADY NY 12301



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 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 **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

(Continued on page 2)

(MVP Awarded a CORE-Certification Seal from CAQH for Compliance with EFT/ERA CORE Operating Rules continued from page 1)

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 **mvphhealthcare.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 **mvphhealthcare.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@mvphhealthcare.com

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

Rochester
RocProviderChanges@mvphhealthcare.com

Mid-Hudson New York
MidHudsonprdept@mvphhealthcare.com

Vermont
vpr@mvphhealthcare.com

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

Medicaid Program Updates

The MVP Harmonious Health Care Plan is a New York State Health and Recovery Plan (HARP) Program Health Benefit Plan

As a reminder, on July 1, 2016, MVP Health Care began offering the MVP Harmonious Health Care Plan, a health benefit plan offered through the New York State Health and Recovery Plan program (HARP). This plan is available to existing Medicaid Managed Care members age 21 and over with serious mental illness and/or substance use disorders, as identified by New York State.

The MVP Harmonious Health Care Plan (Plan Type “MVPH”) provides traditional Medicaid benefits through MVP’s participating provider network, as well as a broad range of Home and Community-Based Services (HCBS) through MVP’s behavioral health vendor, Beacon Health Options. Prior authorization of specific HCBS services is required. Below is a sample MVP Harmonious Health Care Plan Member ID card.

		DOB: xx/xx/xxxx CIN: XXXXXX	Plan Type: MVPH
Member Name JOHN MVPMEMBER		Group#: XXXXXX	
Member ID Number 123456789 00		RxBin: XXXXXX	
		RxPCN: XXX	
		RxGRP: XXXXXX	
PCP Name: Dr. PCP		Primary Care: \$0	
PCP Phone: 123-456-7890		Specialist: \$0	
PCP Office: Primary Medical		Emergency Room: \$0	
Care of Anywhere		Urgent Care: \$0	

For Medical Advice:
Mental Health/Substance Use Disorder Help: 1-844-946-8002
24/7 Online Doctor Visits: myvisitnow.com

For medical advice, call your Primary Care Provider (see front of card for name and number). Emergency: call 911 or go directly to the nearest hospital emergency room.

Send Claims to:
MVP Health Plan, Inc.
625 State Street
P.O. Box 1207
Schenectady, NY 12301-2207

For Providers:
Provider Services Department: 1-800-684-9286
Pharmacies | CVS/Caremark: 1-800-364-6331
mvphealthcare.com/providers

Please note, the MVP Harmonious Health Care Plan is a New York State Government Program under Medicaid Managed Care. Reimbursement for covered plan medical services are set at the level detailed in your MVP Medicaid Managed Care contracted rate, as outlined in your New York State Government Programs Fee Schedule. MVP-participating providers must participate in the MVP Government Programs line of business and have had the HARP products added to their MVP participating provider agreement to be included in the MVP Harmonious Health Care Plan network. To access the Harmonious Health Care Plan Frequently Asked Questions, visit mvphealthcare.com and select *Providers*, then *Reference Library*, then *Guides to MVP Benefits & Plans*.

If you have any questions about this product, please contact your Professional Relations Representative or the MVP Customer Care Center for Provider Services at **1-800-684-9286**.

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.

Medical Policies Approved without Changes in May 2017

Artificial Intervertebral Discs
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.

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

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Get Healthy Practices by Email

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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

President & CEO
MVP Health Care, Inc.

We welcome your comments.

Healthy Practices
MVP Health Care
Professional Relations Department
PO Box 2207
Schenectady, NY 12301



mvphealthcare.com

Professional Relations Updates

MVP Code of Ethics and Business Conduct Summary

MVP Health Care, Inc. ("MVP") provides this Code of Ethics and Business Conduct Summary as part of its commitment to conducting business with integrity and in accordance with all federal, state, and local laws. This summary provides MVP's network providers, vendors, and delegated entities ("Contractors") with a formal statement of MVP's commitment to the standards and rules of ethical business conduct. All MVP contractors are expected to comply with the standards as highlighted in this article.

Protecting Confidential and Proprietary Information

It is of paramount importance that MVP's member and proprietary information be protected at all times. Access to proprietary and member information should only be granted on a need-to-know basis and great care should be taken to prevent unauthorized uses and disclosures. MVP's contractors are contractually obligated to protect member and proprietary information.

Complying with the Anti-Kickback Statute

As a Government Programs Contractor, MVP is subject to the federal anti-kickback laws. The anti-kickback laws prohibit MVP, its employees, and contractors from offering or paying remuneration in exchange for the referral of Government Programs business.

Reviewing the Federal and State Exclusion and Identification Databases

MVP and its Government Programs contractors are required to review the applicable federal and/or state exclusion and identification databases. These database reviews must be conducted to determine whether potential and current employees, contractors, and vendors are excluded from participation in federal and state sponsored health care programs. The federal and state databases are maintained by the Department of Health and Human Services Office of Inspector General, the General Services Administration, the New York State Office of Medicaid Inspector General, and the Social Security Administration (the National Plan and Provider Enumeration System and Death Master File).

Prohibiting the Acceptance of Gifts

MVP prohibits employees from accepting or soliciting gifts of any kind from MVP's current or prospective vendors, suppliers, providers, or customers that are designed to influence business decisions.

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

MVP has policies and processes in place to detect and prevent fraud, waste, and abuse ("FWA"). 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*,

(Continued on page 2)

(MVP Code of Ethics and Business Conduct Summary continued from page 1)

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 (FWA) 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.

Authorizations and Status

Using the eviCore healthcare web portal is the quickest, most efficient way to initiate authorizations and check the status of an existing case.

From the web portal, you can:

- Create an authorization request in minutes
- Access information 24/7
- Save your progress
- Print information

Visit **evicore.com** and select *Providers*, then *Register* to begin initiating authorizations online.

Website Reminder

In the Fall of 2016, MVP refreshed the look and feel of the MVP Health Care website. In addition, MVP is continually updating the information on the website to keep providers and members up-to-date on everything they need to know when working with MVP. If you had saved webpage bookmarks within **mvphealthcare.com** prior to the release of our new website, you are not accessing the most up-to-date information for MVP providers. Please make sure to remove any previous browser bookmarks to **mvphealthcare.com** webpages. In addition, it is recommended that you do not continue to bookmark pages within the **mvphealthcare.com** website in case additional updates to the website are made.

The Centers for Medicare & Medicaid Services (CMS) Benefits and Beneficiary Protections for MVP Medicare Advantage Members

When an MVP Medicare Advantage member receives items and services through referrals by an MVP contracted doctor to a non-contracted doctor, also known as Plan Directed Care, CMS expects that the contracted doctor will coordinate with MVP before making that referral. This is an important step to make sure MVP members are getting medically necessary services covered by MVP’s Medicare Advantage Plan. If a contracted provider is not certain what is covered, they must request a pre-service organization determination by calling **585-325-3114** or **1-800-684-9286** prior to referring the member to a non-contracted provider.

In 2017, MVP will work with contracted providers to review data obtained through claims that have been referred to non-contracted providers for ongoing education.

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*.

Medicaid Program Updates

Refer Individuals to Health Home Care Management

A **Health Home** is a group of health care and service providers working together to make sure individuals get the care and services they need to stay healthy, and reduce hospital and emergency room visits. Once an MVP member is enrolled in a Health Home, they have their own care manager who works with them to gain access and support to medical, behavioral, and social services. Care managers work with members to evaluate services the member may need which include, but are not limited to:

- Support and access to health care providers
- Mental health providers
- Medication and social services (e.g., SNAP, SSD/SSI, transportation)
- Any other community resources that provide support

The Referral Process

First, ask the member if he or she is enrolled in a Case Management Agency. Then, confirm this by doing a check on the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) by visiting **omh.ny.gov** and select Behavioral Health Providers, then *Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)*, then *PSYCKES MEDICAID*. The name of the Health Home will display in the members Clinical Summary if they are in or have been enrolled in a Health Home. Or you can contact MVP to inquire about the members Health Home Care

Management status by calling **914-372-2233** or by email at **healthhome@mvphealthcare.com**. Consent is not required to talk to the Managed Care Organization.

If they are enrolled, contact the Health Home or Care Management Agency to further engage their care manager in the member's care and address any specific needs that you feel the care manager can assist the member with. If there are issues with accessing a Health Home or connecting to a care manager, contact MVP and ask for the Health Home queue and we will call you back.

Additional Information

You may discover that an MVP member, your patient, is enrolled in the MVP Harmonious Health Care Plan, a Health and Recovery Plan (HARP) product, but not enrolled in a Health Home. In this case, please follow the referral process to assure they get into a Health Home.

Community Referral Process for Non-Medicaid Cases

You can send the same referral form to the Local Government Unit of the county in which the MVP member lives. If you need the referral form, please contact **HealthHome@mvphealthcare.com**.

Breastfeeding

MVP recognizes the importance of breastfeeding babies and we are committed to ensuring that breastfeeding support is available for every mom and baby we cover. MVP partners with a breastfeeding education and support program, Corporate Lactation Services. Through

this relationship, MVP is able to offer nursing mothers breastfeeding equipment and access to board certified lactation consultants 365 days-a-year. This support program includes outreach calls placed at specific times to provide mothers with information appropriate for the age of the infant/baby. Members can call with questions or concerns until weaning.

All of these services are offered at no additional charge to our members. To enroll, members can visit **corporatelactation.com** and select *Subsidy Login*, then enter the pass code *MVP2229* or call **1-888-818-5653**.

Smoking Cessation—An Intervention Whose Time is Here

Recent data has shown a reduction in tobacco smoking over the past several years. However, many of your patients, including teenagers, continue to smoke. Helping them quit may be the most important thing you can do for them. Medical literature clearly supports the importance of physician intervention in getting patients to quit and new programs are available to assist in accomplishing this goal.

There are many barriers to getting a smoker to quit. One problem is that many of the ads and brochures focus on complications of smoking that will not occur until later in life. Teenagers and twenty-somethings are notorious for their sense of invincibility and a lack of concern for what may happen in the far future. It is important when communicating with them to point out the more immediate

effects that may impact them sooner. This includes the effects of smoking on appearance, such as stained teeth and yellow fingers, and increased susceptibility to infections, such as pneumonia. It also increases the risk of Type 2 diabetes and may lead to an increased rate of progression in individuals with Type 2 diabetes.

Another factor that may catch the attention of younger smokers is the effect of vasoconstriction on sexual function and fertility. Smoking contributes to the rise of impotence in men and to reduced responsiveness and achievement of orgasm in both men and women. In addition, it may contribute to infertility in women and can increase the risk of pre-term birth, birth defects, and low birth weight during pregnancy, and the risk of otitis, respiratory infections, and Sudden Infant Death Syndrome (SIDS) in newborns and infants.

The longer term effects, which may bear mentioning, include increased risk of lung disease, heart disease, and stroke as well as many types of cancers, including lung, throat, head and neck, colorectal, cervical, blood, pancreas, and kidney. If the risk of lung cancer is not enough to get their attention, maybe the long list of cancers will. It may also help to mention that the risk of dying is three times higher in smokers.

Advise your patients that free support is available from the New York State Smokers' Quitline at **1-866-NY-QUITS** (697-8487) or **nysmokefree.com**. MVP wants to help you keep your patients healthy.

Caring for Older Adults

Preventing the Elderly from Falls

According to the Centers for Disease Control and Prevention (CDC), approximately one in four individuals age 65 or older sustain a fall each year, but fewer than half talk to their health care practitioner about it. This is an important topic of discussion with the elderly. Falls can be largely prevented and injuries such as hip fractures and head trauma reduced. There are several key actions you can take to help your elderly patients reduce the risk of falling:

- Encourage regular exercise—discuss an exercise program with the patient that focuses on increasing leg strength and balance.
- Review medications for those that may cause drowsiness or dizziness as a side-effect or in combination with other medications.

- Ensure they have their vision checked and eyewear adjusted appropriately.
- Discuss tripping/slipping hazards in the home and ways to eliminate them.

Additionally, maintaining strong bones is an important part of reducing fracture risk. Tips to discuss with your patients include:

- Eating a well-balanced diet that contains lots of fruits and vegetables, dairy, and fish, and includes adequate amounts of total calcium intake (1,000 mg per day for men ages 50–70; 1,200 mg per day for women age 51 and older and men age 71 and older). Consider incorporating dietary supplements if diet is insufficient.

- Quitting smoking, as this can further reduce bone density.
- Avoiding excessive alcohol use—heavy use is defined as more than two drinks per day for men and more than one drink per day for women.

MVP offers several free tools to assist practitioners in fall prevention. The MVP Provider Quality Improvement Manual (PQIM) includes:

- Prevention and Treatment of Osteoporosis Guideline from the National Osteoporosis Foundation (NOF)
- FRAX World Health Organization Fracture Assessment Tool

- Medications Considered High-Risk in Adults—this document includes medications that should be used with caution in the elderly. Included in this list are medications that may pose additional fall risk as well as possible alternatives.
- Fall Prevention Brochure that can be given to patients.

To access the PQIM visit mvphealthcare.com and select *Providers*, then *Provider Quality Improvement Manual* under *Quality Programs*. The aforementioned tools can be found in the Caring for Older Adults section.

The Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Important Facts about Falls. Accessed March 20, 2017 at cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html.

Quality Improvement Updates

The Importance of Well Child Visits

As you already know, childhood is the time in life that we see the most rapid change and growth. Therefore it's imperative that children receive frequent well child visits to assess their early development. During these assessments, it is important to conduct physical examinations, as well as assessments of a child's growth and development.

Important milestones you should focus on for the first 15 months of a child's development and beyond include:

- Children must have five or more visits completed by their 15 month birthday.
- Childhood immunizations must be completed by the child's second birthday.
- Lead screening must be completed by the child's second birthday.
- Adolescent immunizations must be completed by the thirteenth birthday.

All of the above visits should be scheduled prior to the child's birthday. MVP does not require well visits to be 366 days apart. A new calendar year equals a new well visit.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Chart documentation for all members ages 3–17 must show evidence of:

- BMI percentile
- Counseling for nutrition
- Counseling for physical activity

Adolescent Preventive Care (APC)

Chart documentation for all members ages 12–17 must show assessment, counseling, or education focusing on:

- Risk behaviors and preventive action associated with sexual activity
- Depression
- Risks of tobacco usage
- Risks of substance use, including alcohol

By sticking to these milestone assessments, a child is more likely to remain healthy during their early development and beyond. Throughout the continuous engagement with your members and their families, it is more likely that you will retain them as patients for a long and healthy lifetime, as well as stay on course with meeting your quality measures.

Annual Notices for MVP Health Care 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 call Professional Relations at the phone number shown on the front page of this newsletter.

HEDIS/QARR and CAHPS Measure Spotlight

Healthcare Effectiveness Data & Information Set (HEDIS) is a nationally recognized set of health care quality measures that contribute significantly to MVP's National Committee for Quality Assurance (NCQA) 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 government also monitor these 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 state Quality Assurance Reporting Requirements (QARR) programs are two examples.

Information on Select HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Measures

Medication Reconciliation Post-Discharge (MRP): This measure is one of the clinical quality indicators that CMS includes in the Star rating program for Medicare Advantage plans.

The MRP measure shows the percentage of Medicare members (ages 18 and older) who had an acute or non-acute inpatient discharge and had a medication reconciliation review completed and documented within 30 days of discharge.

Medication Reconciliation is defined as:

- A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Examples that meet criteria:

- Documentation of the current medications with a notation that references the discharge medication(s) (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the member's current medications with a notation that discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service.
- Notation that no medications were prescribed or ordered upon discharge.

The following documentation must be included in the chart:

- Evidence of medication reconciliation (current versus discharge medications) and the date it was performed.
- Reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse on the date of discharge through 30 days after discharge.

Note: Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required (it can be done over the phone).

Measure Codes Volume 2 for Measure ID MRP

Measure Name	Value Set Name	Code	Definition	Code System
Medication Reconciliation Post-Discharge	Medication Reconciliation	1111F	DSCHRG MED/CURRENT MED MERGE	CPT
Medication Reconciliation Post-Discharge	Medication Reconciliation	99495	TRANS CARE MGMT 14 DAY DISCH	CPT
Medication Reconciliation Post-Discharge	Medication Reconciliation	99496	TRANS CARE MGMT 7 DAY DISCH	CPT

Major 2018 HEDIS Changes

One HEDIS measure will have a significant change from the last HEDIS reporting year that we want to bring to your attention.

Follow-up After Hospitalization for Mental Illness (FUH)

Visits on the date of discharge will no longer count as numerator compliance for this measure. NCQA's rationale for this change includes the fact that an encounter on

the date of discharge should be viewed as an effort to support the patient and improve the likelihood of receiving timely follow-up care. Visits that take place on the date of discharge should not be the only follow-up care patients receive and would not be considered good quality of care on its own; therefore, not meeting the intent of the measure.

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 June 1, 2017

Air Medical Transport: The Exclusion section of the policy was updated to include that air ambulance service is not covered for transport to anyplace other than an acute treatment facility, such as the member's home or a physician's office.

Breast Reduction Surgery (Reduction Mammoplasty): There are no changes to the medical policy criteria or indications.

Cardiac Output Monitor by Thoracic Elec Bioimpedence: There are no changes to the medical policy criteria or indications.

Endovenous Ablation of Varicose Veins: The requirement that a member not stand or sit for extended

periods of time has been removed as an indication from the medical policy. Endovenous mechanochemical catheter is considered experimental/investigational, and therefore is not covered. Anticoagulation therapy Endovenous mechanochemical catheter was added to the exclusions section of the medical policy.

Laser Treatment of Port Wine Stains: There are no changes to the medical policy criteria or indications.

Obstructive Sleep Apnea: Diagnosis: There are no changes to the medical policy criteria or indications.

Oxygen Therapy for Treatment of Cluster Headaches: There are no changes to the medical policy criteria or indications.

Pharmacy Updates

TransactRx

Providers can bill Medicare Part D vaccine claims electronically using TransactRx. This service is available at no cost and will provide real time claim processing for in-office administered vaccines. TransactRx will give you the ability to verify the member's eligibility and benefits, provide the member's out-of-pocket expense, and receive reimbursement information in real-time. Reimbursement will be according to the MVP reimbursement schedule and

Part B covered vaccines (e.g., influenza, pneumococcal) cannot be billed through TransactRx. For additional information, contact TransactRx at **1-866-522-3386** or visit transactrx.com.

Diltiazem Coverage for Medicare Part D Members

The generic for Tiazac 360mg-diltiazem capsules 360mg/24 hr and Taztia XT 360mg are covered on the

Medicare Part D Formulary for 2017. Cardizem CD 360mg and its generic-diltiazem capsule 360mg CD are non-formulary and would require a formulary exception for coverage.

Policy Updates Effective May 1, 2017

Onychomycosis: No changes to this policy.

Diclofenac (topical) Products: Solaraze 3% gel (brand and generic) will now require prior authorization for Commercial members.

Valchlor: No changes to this policy.

Psoriasis Drug Therapy: Taltz added to policy. Stelara moved from medical to pharmacy benefit. Enbrel now covered for patients over 4 years of age for psoriasis.

Lidocaine (topical) Products: No changes to this policy.

Cosmetic Drug Agents: Perlane, Restylane, Tri-Luma, Botox Cosmetic, Juvederm, Kybella, and Avage added to policy.

Select Oral Antipsychotics: Nuplazid added to policy.

Co-pay Adjustment for Medical Necessity: Added language regarding backdate requests to exclusion criteria.

Medicare Part B vs. Part D Determination: Epoprostenol and treprostinil added to infusion pump medications covered under Part B when administered in the home using an infusion pump.

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
Spinraza	Spinal muscular atrophy
Rubraca	Ovarian cancer
Eucrisa	Atopic dermatitis

Drugs Added to Formulary

Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace
Lopinavir-ritonavir sol

Drugs Removed from Prior Authorization

Xiidra	Bevespi Aerosphere
Byvalson	Qbrelis

PRSRT STD
US Postage
PAID
MVP Health Care

625 State Street
Schenectady, NY 12305-2111
mvphealthcare.com



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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
Vermont	1-800-380-3530

Denise V. Gonick

President & CEO
MVP Health Care, Inc.

We welcome your comments.

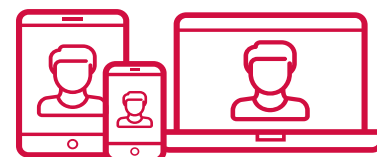
Healthy Practices
MVP Health Care
Professional Relations Department
PO Box 2207
Schenectady, NY 12301



mvphealthcare.com

Professional Relations Updates

Join Online Care Group, the MVP Telemedicine Provider Network for myVisitNow



As of January 1, 2017, many MVP plans include **myVisitNow**—24/7 online doctor visits, powered by American Well. This telemedicine benefit offers eligible MVP members access to urgent care providers, anytime from nearly anywhere in the U.S. We are committed to taking an active role in supporting your patient's health, and your role as their Primary Care Provider (PCP). **myVisitNow** is not designed to replace PCP visits, but to offer our members greater access to care and convenience for urgent care related visits.

If you haven't already done so, please consider joining American Well's Online Care Group to offer online consultations. We see this as an opportunity to evolve patient care, and we want you to be part of it! By joining, you will not only have access to MVP members, but to other American Well users.

To join the already well-established and reputable Online Care Group national network providing online consultations via **myVisitNow**:

- Visit myvisitnow.com and select *Provider Login*, then *Enroll*.
- Email a Curriculum Vitae to ocg.recruiting@americanwell.com.

For more information, visit mvphealthcare.com and select *Providers*, then *Search Providers*, then *New for 2017!* *myVisitNow—24/7 Online Doctor Visits*. Or contact your MVP Professional Relations representative.

Case and Condition Health Management Programs Accepting Referrals

MVP offers dedicated Population Health Management programs to members at a variety of service levels. Drawing on the combined strength of our wellness strategists, registered nurses, social workers, respiratory therapists, physicians, pharmacists, and community health care providers, MVP offers a highly focused, integrated approach to case management that promotes quality, cost-effective health care throughout the care continuum. MVP Case Managers use key principles within the framework of nursing case management established by the American Nursing Association and the Case Management Society of America.

The MVP Condition Health Management program focuses on members with asthma, low back pain, cardiac condition (post-event based), COPD, diabetes, and heart failure.

MVP's Acute Case Management Focuses on High-Risk Target Populations

Factors considered for identifying eligible members for case management include: diagnosis, cost, utilization (emergency room and inpatient admissions), and qualitative variables (social risk, support network), as well as members' willingness to participate in case management.

(Continued on page 2)

(Case and Condition Health Management Programs continued from page 1)

Case management activities also include care of members who undergo organ transplant, have cancer, end-stage renal disease, HIV/AIDS, or experience a high-risk pregnancy. Additional factors for consideration when determining member eligibility include members who are non-adherent to the plan of care and/or members who require additional guidance in navigating their care. Members who experience a critical event or diagnosis can be referred for case management services through multiple avenues.

To make a referral to our Population Health Management program, call **1-866-942-7966**, fax **1-866-942-7785**, or email phmreferrals@mvphealthcare.com.

CMS Medicare Benefits and Beneficiary Protections

When an MVP Medicare Advantage member receives items and services through referrals by an MVP contracted doctor to a non-contracted doctor, also known as Plan Directed Care, The Centers for Medicare & Medicaid Services (CMS) expects that the contracted doctor will coordinate with MVP before making that referral. This is an important step to make sure MVP members are getting medically necessary services covered by MVP's Medicare Advantage Plan. If a contracted provider is not certain what is covered, they must request a pre-service organization determination prior to referring the member to a non-contracted provider by calling **585-325-3114** or **1-800-684-9286**.

In 2017, MVP will be working with contracted providers to review data obtained through claims that have been referred to non-contracted providers for ongoing education.

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 Demographic Change 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 on letterhead to the appropriate fax number or email below.

East New York and Massachusetts

518-836-3278

eastpr@mvphealthcare.com

Central, Mid-State, or Southern Tier New York

315-736-7002

centralprdept@mvphealthcare.com

Rochester

585-327-5747

RocProviderChanges@mvphealthcare.com

Mid-Hudson New York

914-372-2035

MidHudsonprdept@mvphealthcare.com

Vermont

802-264-6555

vpr@mvphealthcare.com

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

Provider Resource Manual Update

FX Modifier Claim Payment Reduction Notification

MVP is changing how the technical component fees are paid for radiology claims billed with an FX modifier for all lines of business. This change will be effective for April 1, 2017 and subsequent dates of service.

The FX modifier **must be used** when billing the technical components of X-rays taken using film. This change is being made pursuant to Section 502(a)(1) of the Consolidated Appropriations Act of 2016 and is intended to encourage providers to transition from traditional x-ray imaging to digital radiography. The technical

component payment of global procedures billed with the FX modifier will be reduced by 20 percent. Claims billed with the TC and FX modifier and paid per the CMS provider fee schedule/ Outpatient Prospective Payment System (OPPS) will be reduced by 20 percent.

For more information, *Sign In* to your MVP account at mvphealthcare.com and select *MVP Provider Resource Manual* under *Online Resources*. Please refer to Section 15: Payment Policies, Modifier policy.

Medicaid Program Updates

Little FootprintsSM Prenatal Care Program for High-Risk Pregnancies

MVP offers a high-risk prenatal care program called **Little Footprints**. Little Footprints provides additional clinical expertise for expectant mothers.

The goal of the Little Footprints program is to promptly identify female members vulnerable to high-risk pregnancy (multiple births, infertility, history of miscarriage, etc.) and provide the member with care coordination and prenatal education. The program involves monthly telephonic contact with an MVP Case Manager or bilingual Maternity Care Coordinator who follows each member individually and develops an education plan in conjunction with the pregnancy assessments and screenings.

Ongoing phone calls are scheduled with the member to encourage healthy behavior and provide education on topics such as fetal development, diet, nutrition, and exercise. Members are followed post-delivery, and are assessed for postpartum depression and a newborn assessment is completed. Members are advised to follow up with their physicians post-delivery and verify that an appointment with the pediatrician has been scheduled.

Expectant mothers are mailed educational information packets upon enrollment and delivery. Those members who are not eligible or decline to participate in the Little Footprints program are referred to the **Healthy Starts** program for an educational packet via mail. The Healthy Starts program gives mothers-to-be information that helps them stay healthy, learn about pregnancy, and prepare for delivery. Medicaid members who are not eligible or decline to participate in the Little Footprints program will receive the same informational mailings as those enrolled in the program.

To make a referral to our Little Footprints program, call **1-866-942-7966**, fax **1-866-942-7785**, or email phmreferrals@mvphealthcare.com.

Breastfeeding

MVP recognizes the importance of breastfeeding babies and we are committed to ensuring that breastfeeding support is available for every mom and baby we cover. MVP partners with a breastfeeding education and support program, Corporate Lactation Services. Through this relationship, MVP is able to offer nursing mothers breastfeeding equipment and access to board certified lactation consultants 365 days-a-year. This support program includes outreach calls placed at specific times to provide mothers with information appropriate for the age of the infant/baby. Members can call with questions or concerns until weaning.

All of these services are offered at no additional charge to our members. To enroll, members can visit **corporatelactation.com** and select *Subsidy Login*, then enter the pass code **MVP2229** or call **1-888-818-5653**.

Financial Incentives Relating to Utilization Management (Utilization Management Notification)

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 Program to ensure appropriate use of services. The MVP Utilization Management 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 Utilization Management 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.

Compliance Updates

Depression During Winter

Winter represents an increased risk for depression due to the shorter, darker days and decreased opportunities for physical activity. Helping patients recognize the symptoms

of depression and educating them on the treatment opportunities may help mitigate the impact of seasonal depression. To help you help your patients, Beacon Health Options® offers a PCP Hotline that provides "Curbside

Consults” related to behavioral health issues. PCPs and specialists may contact the Beacon Health Options PCP and Peer Advisor’s Scheduling Line for consultation at **1-877-241-5575**. Representatives are available Monday–Friday, 9 am–6 pm Eastern Time.

Helping Adolescent Patients Find an Adult Care Provider

Patients entering adulthood (ages 18 and up) may want help or need encouragement to transition from a pediatrician to an adult care provider. MVP offers resources to help you serve your adolescent patients.

MVP’s online provider directory enables members to search for and select an adult provider by several preferences such as location, board certification, gender, or language spoken. Members can visit mvphealthcare.com and select *Find a Doctor* to search for providers.

The MVP Customer Care Center is available to assist older adolescent members with transitioning from a pediatrician and/or pediatric specialists to an adult provider when they wish to make the change. Members can call the MVP

Customer Care Center at the phone number on the back of their MVP Member ID card.

MVP offers a template letter to make it easy for you to contact your patients over the age of 18 to help make the transition from your practice to an adult practice. Contact your MVP Clinical Reporting Coordinator for more details.

Talk With Your Patients About Aspirin Use

Aspirin use as treatment for heart disease is often misunderstood. The best resource for your patients is you, their health care provider. Talk with your patients about appropriate use of aspirin for the prevention of heart attacks. Without the benefit of your expertise, television commercials can be very persuasive and do not clearly explain the risks as well as the benefits.

No one knows your patients better than you do, and they trust your recommendations. Help your patients make the right decision. The American Heart Association’s website offers more details, presented to a non-clinical audience which may be a helpful resource for your patients. Visit heart.org and type “aspirin” in the *Search* field to find helpful web content and downloadable materials.

Quality Improvement Updates

HEDIS®/QARR and CAHPS® Measure Spotlight

In prior issues of this newsletter we have introduced several HEDIS measures that MVP monitors on an ongoing basis and submits to the National Committee for Quality Assurance (NCQA), and the state and federal governments annually. The following describes additional measures MVP is focusing on for 2017.

Measure: AAB

Avoidance of Antibiotics for Adults with Acute Bronchitis

Compliance is achieved when individuals (ages 18–64) with a diagnosis of acute bronchitis are **not** given a prescription for an antibiotic.

- The measure is reported as an inverted rate—a higher rate indicates appropriate treatment (those not given an antibiotic).
- This is an administrative measure and does not utilize chart review. Claims are reviewed to check for an antibiotic prescription on or up to three days after the date of service for any outpatient or ED visit with a diagnosis of acute bronchitis.
- Members with comorbidities may be removed from

this measure—if an antibiotic is prescribed be sure to document any comorbidities.

Measures: W15, W34, AWC

Well-Child/Adolescent Measures

Well-Child Visits in the First 15 Months of Life (W15):

This measure reports seven different rates according to the number of well-child visits within the first 15 months of life. Separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34):

This measure reports the percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.

Adolescent Well-Care Visits (AWC):

This measure reports the percentage of enrolled members ages 12–21 who had at least one comprehensive well-

care visit with a PCP or an OB/GYN practitioner during the measurement year.

Criteria for W15, W34, and AWC measures:

- Visits must take place with a PCP, but it does not need to be the PCP assigned to the member.
- Services specific to an acute or chronic condition **do not count** toward the measure.
- Services may occur over several visits as long as they are within the time frame of the measure.

Medical records may be reviewed for this measure, and notations must include the date of the visit with the PCP and **all** of the following:

- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance

Additional criteria for W34 and AWC measure:

- Visits to school-based clinics with practitioners whom MVP would consider PCPs may be counted for the W34 and AWC measures. For these visits to count there must be documentation of a well-child exam in the medical record or administrative system in the time frame specified by the measure.

Measure: CCS

Cervical Cancer Screening (CCS)

This measure reports the percentage of women ages 21–64 who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every three years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Medical records may be reviewed for this measure and notations must include both of the following:

- A note indicating the date when the cervical cytology was performed.
- The result or finding.

For women age 30–64 who did not meet the first criteria (evidence of cervical cytology every three years), medical records must include both of the following:

- A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.
- The results or findings.

Note—the following **do not count** toward the measure:

- Lab results that state the sample was “inadequate” or that “no cervical cells were present”.
- Biopsies do not count because they are diagnostic (not a screening).

Members may be **excluded from this measure** for several reasons. Be sure to include appropriate documentation in the medical record:

- Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.
- Evidence of a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix meets criteria for exclusion.
- Documentation of “complete,” “total,” or “radical” abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet criteria:
 - Documentation of a “vaginal Pap smear” in conjunction with documentation of “hysterectomy.”
 - Documentation of hysterectomy in combination with documentation that the patient no longer needs Pap testing/cervical cancer screening.

Measure: FUH

Follow-Up After Hospitalization for Mental Illness (FUH)

This measure reports the percentage of discharges for members ages 6 and up who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days of discharge.
- The percentage of discharges for which the member received follow-up within seven days of discharge.

Key points about this measure:

- This is an administrative measure and does not utilize chart review.
- Visits that occur on the date of discharge do count toward this measure.

Reminder—Change for HEDIS 2017

We wanted to remind you about a change we mentioned in the last issue of *Healthy Practices* for the **Immunizations for Adolescents (IMA)** measure—the HPV vaccine has been added as a requirement for this measure. Now this measure requires three doses of HPV vaccine by age 13. **This requirement for the HPV vaccine is for both boys and girls.**

MVP understands the challenges providers face to help educate patients and influence behavior change. We have various resources and tips available to support your work, including:

Provider Quality Improvement Manual (PQIM)

The PQIM has clinical guidelines for providers as well as many tools to assist with practice and educating patients. To find the PQIM, visit mvphealthcare.com and select *Providers*, then *Quality Programs*. The manual is organized by clinical topics, including those addressed in the aforementioned HEDIS measures.

Bright Futures

Additional support in relation to the well-child/adolescent measures is available through the Bright Futures tools available on the American Academy of Pediatrics (AAP) website at aap.org. Many tools are available at no charge to practices to assist in pediatric care. The pocket guide is

separated by age and contains useful information on the types of screening and anticipatory guidance that should take place at each visit. This covers the points NCQA has instructed health plans to look for when reviewing charts for evidence of a well-care visit.

Mental Health/Substance Use and Coordination of Care

Individuals with mental health/substance use issues often have trouble following through with recommendations. If a patient has been hospitalized for a mental health issue, it is important to coordinate with their behavioral health specialist to ensure they receive the appropriate follow-up care. Beacon Health Options is also there to assist patients with mental health/substance use issues in New York State. Their Intensive Case Management (ICM) program is designed to help patients with serious mental illness and those who have been hospitalized. To contact a Beacon Case Manager, call **1-877-390-9652**. For members in Vermont please call PrimariLink at **1-800-320-5895**.

Medical Policy Updates

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

Continuous Passive Motion Devices: There are no changes to the medical policy criteria. This medical policy is effective April 1, 2017. It was erroneously reported in the January/February *Healthy Practices* Issue to be effective February 1, 2017.

Deep Brain Stimulation: There are no changes to the medical policy criteria.

Electromyography and Nerve Conduction Studies: There are no changes to the medical policy criteria.

Evaluation of New Technology: There are no changes to the evaluation of new technology process.

Hip Surgery (Arthroscopic) for Femoroacetabular Impingement (FAI), Acetabular Labral Tears, and Snapping Hip Syndrome: There are no changes to the medical policy criteria. Effective January 1, 2017, CPT Codes 29914, 29915, and 29916 do not require prior authorization.

Implantable Cardioverter Defibrillators, Implantable Dual Chamber Automatic Defibrillators, and Cardiac Resynchronization Devices: There are no changes to the medical policy criteria.

Investigational Procedures, Devices, Medical Treatments, and Tests: There are no changes to the medical policy criteria.

Medical Policy Development, Implementation, and Review Process: There are no changes to the evaluation of medical policy review process.

Negative Pressure Wound Therapy Pumps: There are no changes to the medical policy criteria. The policy language regarding subsequent negative pressure wound therapy (NPWT) following discharge: NPWT will be covered when treatment is ordered to continue beyond discharge to the home setting.

Procedures for the Management of Chronic Spinal Pain and Chronic Pain: This policy addresses trigger point

injections, sacroiliac (SI) joint injections (diagnostic and therapeutic), lumbar epidural injections (interlaminar, caudal, and transforaminal approaches). Previously, this policy addressed facet joint injections, which are now addressed in the MVP Radiofrequency Neuroablation (Rhizotomy), Facet Joint Injections, Medial Branch Blocks, Procedures for Chronic Pain.

Radiofrequency Neuroablation (Rhizotomy), Facet Joint Injections, Medial Branch Blocks, Procedures for Chronic Pain: This policy addresses facet joint injections (diagnostic and therapeutic) and radiofrequency thermal medial branch radiofrequency neurotomy. Previously this policy was titled Radiofrequency Neuroablation Procedures

for Chronic Pain. The current title is MVP Radiofrequency Neuroablation (Rhizotomy), Facet Joint Injections, Medial Branch Blocks, Procedures for Chronic Pain.

Wheelchairs (Manual): There are no changes to the medical policy criteria.

Temporomandibular Joint Dysfunction (NY and VT versions): There are no changes to the medical policy criteria.

Transcatheter Aortic Valve Replacement: There are no changes to the medical policy criteria.

Vision Therapy (Orthoptics, Eye Exercises): There are no changes to the medical policy criteria.

Pharmacy Updates

Out-of-Area Pharmacy Diabetic Supply Prescriptions

MVP has been made aware of out-of-area pharmacies faxing providers prepopulated diabetic supply prescription forms on behalf of the patient. These forms frequently contain orders for insulin, blood glucose meter, test strips, a high-cost compounded wound cream, and vitamin supplements. Upon further investigation we have learned that often the member has not requested these services from the pharmacy. If your office receives one of these prescriptions please verify if the member has initiated the request, and if the medications and supplies are needed.

If you would like to report any suspicious activity, please contact the MVP Special Investigations Unit at **1-877-835-5687**.

Authorized Agents for Prior Authorization Requests

MVP will only accept prior authorizations or communications from the prescribing health care provider or authorized agent. An authorized agent is someone employed by the prescriber and has access to the patient's medical records, such as a nurse or medical assistant. A pharmacy or pharmacist cannot be an authorized agent. Therefore, prior authorization requests and communications regarding requests received via phone or fax from a pharmacy will not be accepted. If you have any questions, please call MVP Professional Relations at **1-800-684-9286**.

Policy Updates Effective February 1, 2017

Lyme Disease/IV Antibiotic Treatment: No changes to this policy.

Zyvox (linezolid): No changes to this policy.

Solodyn (minocycline): Approval criteria and exclusions updated.

Doryx/Oracea (doxycycline): Approval criteria for both Doryx and Oracea updated.

Mepron (atovaquone): No changes to this policy.

Hepatitis C Treatment: Preferred agents updated, Eplclusa will be preferred for the treatment of genotypes 2 and 3 infections.

Antibiotic/Antiviral Prophylaxis: No changes to this policy.

Government Programs Over-The Counter (OTC) Drug Coverage: No changes to this policy.

Patient Medication Safety: No changes to this policy.

Compounded (Extemporaneous) Medications: No changes to this policy.

Valchlor: No changes to this policy.

Onychomycosis: Approval duration for Kerydin added.

Quantity Limits for Prescription Drugs: Quantity limits added for long acting stimulants, Emend suspension, Varubi tablets, Adrenaclick, Evzio, and Plan B (Medicaid only).

Policy Updates Effective April 1, 2017

Acthar: No changes to this policy.

Growth Hormone Therapy: No changes to this policy.

Infertility Drug Therapy: Endometrin and Crinone will require prior authorization if member is not between the ages of 21–44.

Disposable Insulin Delivery Devices: No changes to this policy.

Metformin ER: No changes to this policy.

Kuvan: No changes to this policy.

Male Hypogonadism: Medicare variation updated; Testopel will require prior authorization if quantity is greater than 10 pellets. Medicaid variation updated; all brand name testosterone products will require failure of Tier 1 agents.

Transgender Policy: No changes to this policy.

Select Oral Antipsychotics: New Policy Vraylar will require prior authorization.

Select Injectables for Asthma: Nucala and Cinqair will require prior authorization.

Physician Prescriptions Eligibility: No changes to this policy.

Prescribers Treating Self or Family Members: No changes to this 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
Inflectra	RA, AS, PS, Crohn's, UC
Lartruvov	Soft tissue sarcoma
Vemlidy	Chronic hepatitis B
Zinplava	Reduce recurrence of C. difficile
Adlyxin	Type 2 DM
Soliqua	Type 2 DM
Basaglar	Type 1 and 2 DM

Drugs Added to Formulary

Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace

Aprepitant capsules	Ergotamine w/caffeine
Epinephrine auto injection (Tier 1 marketplace)	Ezetimibe
Oseltamivir capsules	Quetiapine XR
Rasagiline	

Drugs Removed from Prior Authorization

Briviact	Cabometyx
Probuphine kit	Tecentriq

PRSR STD
US Postage
PAID
MVP Health Care

625 State Street
Schenectady, NY 12305-2111
mvphealthcare.com



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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

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

President & CEO
MVP Health Care, Inc.

We welcome your comments.

Healthy Practices
MVP Health Care, Inc.
Professional Relations Department
PO Box 2207
Schenectady, NY 12301

Professional Relations Updates

MVP Provider Resource Manual

MVP updates Provider policies and procedures in the Provider Resource Manual on a quarterly basis and posts them on the MVP website. Policy updates are published 30 days in advance of the effective date to allow providers to review these policy changes. All policies are effective on the first day of each quarter unless otherwise stated in the Provider Resource Manual.

MVP's contracts require providers to follow all MVP policies and procedures, so it is imperative that providers continue to review the Provider Resource Manual on a quarterly basis for all policy updates. To view the MVP Provider Resource Manual, visit mvphealthcare.com and *Sign In/Register*, and then select *Online Resources*.

Preventative Care Policy

MVP has developed a new Preventative Care Payment policy located in Section 15 of the Provider Resource Manual. The Preventative Care policy houses all services that are covered by MVP as it relates to State and Federal guidelines and MVP benefits. Most of the services listed in this policy are covered in full at no cost-share to the member. MVP will update Providers on new policies as they become effective as it relates to preventative care; however providers should also be reviewing this policy on a quarterly basis.

CMS Benefits and Beneficiary Protections

When a member receives items and services through referrals by a MVP-contracted provider to a non-contracted provider, the Centers for Medicare & Medicaid Services (CMS) expects that the contracted provider will coordinate with MVP before making that referral. This is important step that ensures MVP Medicare members are getting medically necessary services covered by their MVP Medicare Advantage Plan. If a contracted provider is not certain what is covered, they should request a pre-service organization determination prior to referring the member to a non-contracted provider by calling **585-325-3114** or **1-800-999-3920**.

In 2017, MVP Professional Relations Representatives will be working directly with contracted providers on a monthly basis to review data obtained through claims that have been referred to non-contracted providers for on-going education.

NY44 Health Benefits Plan Trust Member Identification Cards

This is a reminder to all providers that NY44/MVP members will need to produce their NY44/MVP Medical ID card as well as their Pharmacy Benefits Dimensions (PBD) RX ID card at the time of service. For NY44/MVP members requiring specialty drugs, providers will need to contact Pharmacy Benefits Dimensions Member Services Department at **1-888-878-9172** or **716-635-7880** before drugs are administered.

MVP Member Identification Cards

MVP continuously seeks to improve our business processes. We are excited to announce that we now have new Member ID cards for 2017. MVP will launch a newly designed Member ID card for our Commercial, Medicaid, and Medicare members. The 2017 ID cards feature more clearly organized member and provider information and a new design element in an effort to make health care simpler for our members, providers, and employer groups.

MVP Point of Service Member ID Card

 Point of Service	Subscriber Name John Doe Subscriber ID Number XXXXXXXXXX
Group#: XXXXXX RxBIN: XXXXXXXX RxPCN: XXX RxGRP: XXXXXX	Primary Care: Specialist: Urgent Care: Emergency Room:
Cigna	

mvphealthcare.com Member Customer Care Center: 1-888-687-6277 TTY: 1-800-662-1220 Pharmacy Information: 1-866-284-7134 Mental Health/Substance Use Disorder help: 1-800-568-0458 24/7 Online Doctor Visits: myvisitnow.com CIGNA networks available outside of MVP NY & VT Service Area only for covered urgent/emergency or prior authorized out of network care	Provider Services Department: 1-800-684-9286 Pharmacies CVS/caremark: 1-800-364-6331 mvphealthcare.com/providers
Send Claims to: MVP Health Plan, Inc. 625 State Street P.O. Box 2207 Schenectady, NY 12301-2207	MultiPlan BROADBENT HOUSE CARE

MVP Gold Value HMO-POS Member ID Card

 Gold Value HMO-POS	Member Name JOHN MVPMEMBER Member ID Number 123456789 00
RxBIN: 004336 RxPCN: MEDDADV RxGRP: MVPMEDV	Primary Care: \$20 Specialist: \$40 Emergency Room: \$75 Urgent Care: \$40
MedicareRx	

mvphealthcare.com Medicare Customer Care Center: 1-800-665-7924 TTY: 1-800-662-1220 Pharmacy Info: 1-866-494-8829 TTY 711 24/7 Online Doctor Visits: myvisitnow.com	Provider Services Department: 1-800-684-9286 Pharmacies CVS/caremark: 1-800-364-6331 mvphealthcare.com/providers
Send Claims to: MVP Health Plan, Inc. 625 State Street P.O. Box 2207 Schenectady, NY 12301-2207	Prescription Claims to: CVS Caremark P.O. Box 52066 Phoenix, AZ 85072-2066

MVP will pay Medicare providers according to Medicare fee schedule. Medicare Limiting Charges apply to non-contracted providers and out of network services. DO NOT bill Original Medicare.

MVP HMO Member ID Card

 HMO	Subscriber Name JOHN MVPMEMBER Subscriber ID Number XXXXXXXXXX
Group#: XXXXXX RxBIN: XXXXXXXX RxPCN: XXX RxGRP: XXXXXX	Primary Care: Specialist: Urgent Care: Emergency Room:
Cigna	

mvphealthcare.com Member Customer Care Center: 1-888-687-6277 TTY: 1-800-662-1220 Pharmacy Information: 1-866-284-7134 Mental Health/Substance Use Disorder help: 1-800-568-0458 24/7 Online Doctor Visits: myvisitnow.com CIGNA networks available outside of MVP NY & VT Service Area only for covered urgent/emergency or prior authorized out of network care	Provider Services Department: 1-800-684-9286 Pharmacies CVS/caremark: 1-800-364-6331 mvphealthcare.com/providers
Send Claims to: MVP Health Plan, Inc. 625 State Street P.O. Box 2207 Schenectady, NY 12301-2207	MultiPlan BROADBENT HOUSE CARE

MVP Medicaid Managed Care Member ID Card

 Plan Type: MVPMM	Member Name JOHN MVPMEMBER Member ID Number 800000XXX 00
DOB: 02/01/2010 CIN: XX12345X	Group#: 241160 RxBIN: 004336 RxPCN: ADV RxGRP: MVP625
PCP Name: Dr. PCP PCP Phone: 123-456-7890 PCP Office: Primary Medical Care of Anywhere	Primary Care: \$0 Specialist: \$0 Emergency Room: \$0 Urgent Care: \$0

mvphealthcare.com Customer Care Center: 1-800-852-7826 TTY: 1-800-662-1220 Pharmacy Info: 1-866-832-8077 Mental Health/Substance Use Disorder Help: 1-800-852-7826 24/7 Online Doctor Visits: myvisitnow.com	For medical advice, call your Primary Care Provider (see front of card for name and number). Emergency: call 911 or go directly to the nearest hospital emergency room.
Send claims to: MVP Health Plan, Inc. 625 State Street P.O. Box 2207 Schenectady, NY 12301-2207	For Providers: Provider Services Department: 1-800-684-9286 Pharmacies CVS/caremark: 1-800-364-6331 mvphealthcare.com/providers

MVP Harmonious Health Care Plan Member ID Card

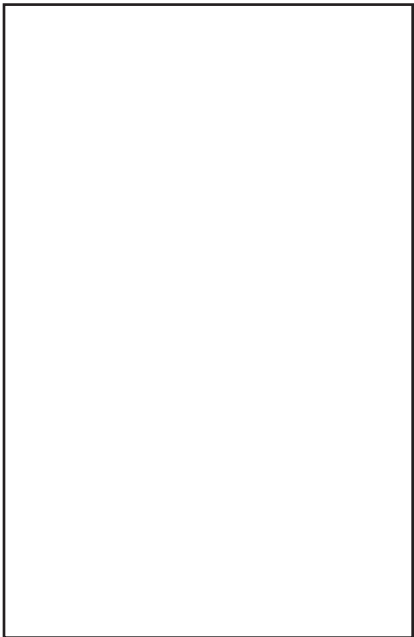
 Plan Type: MVPH	Member Name JOHN MVPMEMBER Member ID Number 800000XXX 00
DOB: 02/01/2010 CIN: XX12345X	Group#: 241160 RxBIN: 004336 RxPCN: ADV RxGRP: MVP625
PCP Name: Dr. PCP PCP Phone: 123-456-7890 PCP Office: Primary Medical Care of Anywhere	Primary Care: \$0 Specialist: \$0 Emergency Room: \$0 Urgent Care: \$0

mvphealthcare.com Customer Care Center: 1-844-946-8002 TTY: 1-800-662-1220 Pharmacy Info: 1-866-832-8077 Mental Health/Substance Use Disorder Help: 1-844-946-8002 24/7 Online Doctor Visits: myvisitnow.com	For medical advice, call your Primary Care Provider (see front of card for name and number). Emergency: call 911 or go directly to the nearest hospital emergency room.
Send claims to: MVP Health Plan, Inc. 625 State Street P.O. Box 2207 Schenectady, NY 12301-2207	For Providers: Provider Services Department: 1-800-684-9286 Pharmacies CVS/caremark: 1-800-364-6331 mvphealthcare.com/providers

New Office Posters Enlighten Members to the High Cost of Health Care Services

As part of MVP's effort to raise awareness about the importance of having a primary health care provider, we have produced an informative poster available to display within your practice.

The poster provides guidance to your patients about how they should think about health care services—particularly when their primary physician's office is closed.



With the prevalence of high deductible plans, it is more important than ever for patients to act as consumers when considering their treatment options. Today more than ever, it is important for them to understand the cost variations by site-of-service. Non-emergent emergency room services have a significant cost impact on patients when more appropriate options are available. We think this information will help initiate informative dialogue between providers and members when considering cost.

To receive your copies of the poster, please contact your MVP Professional Relations Representative.

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 Demographic Change 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 on letterhead to the appropriate fax number or email below.

East New York and Massachusetts

518-836-3278 **eastpr@mvphealthcare.com**

Central, Mid-State, or Southern Tier New York

315-736-7002 **centralprdept@mvphealthcare.com**

Rochester

585-327-5747

RocProviderChanges@mvphealthcare.com

Mid-Hudson New York

914-372-2035

MidHudsonprdept@mvphealthcare.com

Vermont

802-264-6555

vpr@mvphealthcare.com

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

Quality Improvement Updates

HEDIS® and New York State QARR Data Collection Begins in February 2017

The MVP Quality Improvement (QI) Department will begin its annual Healthcare Effectiveness Data and Information Set (HEDIS); and New York State Department of Health Quality Assurance Reporting Requirements (QARR) medical record reviews. HEDIS and QARR are sets of standardized performance measures designed to ensure that consumers and purchasers have the information they need to reliably compare managed health care plans. Managed care organizations are required to report their rates to the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), the New York State Department of Health, and the Vermont Department of Financial Regulation.

Every year, the collected HEDIS data is used to guide the design and implementation of our health management activities, measure MVP's health management programs effectiveness, and measure our performance against other health plans. In 2017, reviews will include the assessment of the clinical performance in the following areas:

- Childhood and adolescent immunizations, including meningococcal vaccine, tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), and Human Papillomavirus Vaccine
- BMI assessment
- Colorectal cancer screening
- Comprehensive diabetes care
- Controlling high blood pressure
- Prenatal and postpartum care

- Cervical cancer screening
- Medication reconciliation upon discharge for the Medicare population

MVP has contracted with Interim HealthCare®, JRC Health Care Consulting, and Aerotek for registered nurses to help our QI staff collect data from medical records. A representative may contact your office to schedule the medical record review. We appreciate your cooperation and will make every effort to minimize any impact the review may have on your office operations. If your office will allow access to the medical records remotely, and you would prefer that the medical record review be conducted remotely to minimize disruption to your office, please use the contact number below.

Please note: HEDIS/QARR are part of "health care operations" and, therefore, the Health Insurance Portability and Accountability Act (HIPAA) does not require authorization from the individuals to release their protected health information (PHI) for health care operations activities. MVP has strict standards for the collection and storage of this information. Thank you in advance for your cooperation and support during these important quality activities.

If you have questions, call Michael Farina in the MVP Quality Management Department at **518-388-2463**.

Breast Cancer Screening Mandate Updates

Effective January 1, 2017, New York State has amended the current insurance law to increase access to care for Breast Cancer screening. The mandate indicates that members must have access to Diagnostic Mammograms,

Breast Ultrasounds, and/or Breast MRIs. This includes Mammography's provided upon the recommendation of a physician, for women of any age who have a prior history of breast cancer or a first degree relative with a prior history of breast cancer, a single baseline mammogram for women age 35–39, and an annual mammogram for women over age 40. Insurers will be prohibited from charging the insured, either in the form of an annual deductible, co-insurance, or a co-payment for these diagnostic services. These services will be covered at no cost to the member when the services are obtained from an MVP participating provider.

In addition, the mandate requires extended hours for mammography screenings to increase access to these services for members. Mammogram providers, specifically hospitals, and extension clinics, certified as a mammography facility pursuant to the Mammography Qualified Standards Act (MQSA), are required to provide extended hours for mammography services. The legislation requires that these extended hours be offered at least twice a week for two hours in the early morning, evening, or weekend.

Breastfeeding Support

MVP recognizes the importance of breastfeeding babies and we are committed to ensuring that breastfeeding support is available for every mother and child we cover. We now offer a comprehensive lactation support program through Corporate Lactation Services that provides the necessary equipment and guidance while breastfeeding.

Through this relationship with Corporate Lactation Services, MVP offers nursing mothers breastfeeding equipment and access to board certified lactation consultants 365 days-a-year. This support program includes outreach calls placed at specific times to provide mothers with information appropriate to the age of their child. Moms can also call in with questions or concerns until weaning.

All of these services are offered at no additional charge to our members. Benefit limitations may apply. Members may call the MVP Customer Care Center at the phone number on the back of their Member ID card to see if they qualify.

To enroll in this support program, members can visit **corporatelactation.com** and select *Subsidy Login*, then enter the company code, **MVP2229**. Members can contact Corporate Lactation Services by calling **1-888-818-5653**.

Case and Condition Health Management Programs Accepting Referrals

MVP offers dedicated Population Health Management programs to members at a variety of service levels. Drawing on the combined strength of our wellness strategists, registered nurses, social workers, respiratory therapists, physicians, pharmacists, and community health care providers, MVP offers a highly focused, integrated approach to management that promotes quality, cost-effective health care throughout the care continuum. MVP Case Managers utilize key principles within the framework of nursing case management established by the American Nursing Association and the Case Management Society of America.

MVP's Condition Health Management program focuses on members with:

- Asthma
- Low back pain
- Cardiac condition (post-event based)
- COPD
- Diabetes
- Heart failure

MVP's Acute Case Management focuses on high-risk target populations.

Factors considered for identifying eligible members for case management include: diagnosis, cost, utilization (emergency room and inpatient admissions) and qualitative variables (social risk, support network), as well as members' willingness to participate in case management.

Case management activities also include care of members who undergo organ transplant, have cancer, end stage renal disease, HIV/AIDS, or experience a high-risk pregnancy. Additional factors for consideration when determining member eligibility include members who are non-adherent to the plan of care and/or members who require additional guidance in navigating the health care continuum. Members who experience a critical event or diagnosis can be referred for case management services through multiple avenues.

To make a referral to our Population Health Management program, call **1-866-942-7966**, fax **1-866-942-7785**, or email **phmreferrals@mvphealthcare.com**.

Caring for Older Adults

New for 2017: Wellness Rewards for Medicare Members

MVP is encouraging Medicare members to stay up-to-date with important preventive screenings by including a Wellness Rewards incentive on most 2017 MVP Medicare Advantage plans.

With Wellness Rewards, Medicare Advantage members can earn a \$75 gift card by:

- Scheduling a Welcome to Medicare or Annual Wellness visit (see next article).
- Asking the provider to complete a simple form confirming the member has received select preventive services, including a colorectal cancer screening within the recommended Medicare guidelines and a flu shot for the current flu season.
- Submitting the completed form to MVP to receive the reward.

Wellness Rewards are not available to SmartFund™ (MSA) plan members.

The Wellness Rewards Screening form can be downloaded by visiting mvphealthcare.com and selecting *Members*, then *Medicaid member? Get Started*, then *Live Well*, then *Learn more about Wellness Rewards*.

Welcome to Medicare and Annual Wellness Visits

The Welcome to Medicare or Annual Wellness visits (as defined by Medicare) are an important part of a Medicare member's overall preventive care. The visit is a good time to talk about the member's overall health, medications taken, and any preventive screenings needed, as well as wellness topics like the importance of physical activity, fall risk, home safety, nutrition, bladder control issues, hearing loss, and quitting tobacco. You and the member can also develop or update a personal health plan or "Health Risk Assessment" to prevent disease and disability based on current health and risk factors.

There are specific codes to bill for these visits:

- G0402 (Welcome to Medicare initial preventive physical exam or IPPE)
- G0438 (Initial Wellness Visit)
- G0439 (Subsequent Annual Wellness Visit)

For more information, visit cms.gov and search for *The ABCs of the Initial Preventive Physical Examination (IPPE)* and *The ABCs of the Annual Wellness Visit (AWV)* education materials.

Participating in the Welcome to Medicare or Annual Wellness visits is the first step for MVP Medicare members to earn their \$75 Wellness Reward.

Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the November and December 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 *Benefit 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 February 1, 2017

Habilitation Services for Individual and Small Group

Products (New): Habilitation Services is a new policy for individual and small group products only effective January 1, 2017. The policy outlines criteria for both inpatient and outpatient settings. Criteria for inpatient habilitation services follow the same criteria that are used for acute inpatient rehabilitation admission in regards to requirements and number of days. The second set of criteria is for services in a Skilled Nursing Facility and must also meet Skilled Nursing Facility admission criteria. Outpatient section must meet requirements documented in both medical records requirement section and

habilitation services section of the medical policy.

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

Allergy Testing: The medical policy was updated with a Medicaid Variation for In vivo/In vitro testing and oral ingestion challenge testing.

Chiropractic Care: There are no changes to the medical policy criteria.

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

Colorectal Cancer Susceptibility Genetic Testing (New):

This medical policy Familial Adenomatous Polyposis (FAP) and Attenuated Adenomatosis Polyposis (APAP) addresses MUTYH-Associated Polyposis testing Lynch syndrome (LS) or (hereditary nonpolyposis colorectal cancer, (HNPCC) Microsatellite instability (MSI) testing or immunohistochemical (IHC) of tumor tissue and Cologuard. All the aforementioned tests are covered when medical policy criteria is met. There is a Medicaid Variation for Lynch Syndrome genetic testing.

Custodial Care: There are no changes to the medical policy criteria.

Electrical Stimulation Devices and Therapies:

Previously Electrical Tumor Treatment Field Therapy was considered investigational and therefore not covered. Electrical Tumor Treatment Field Therapy is covered when medical policy criteria are met for when used with adjuvant temozolomide or as monotherapy for recurrent supratentorial glioblastoma

Epidermal Nerve Fiber Testing: There are no changes to the medical policy criteria.

Genetic Counseling and Testing: The colorectal cancer genetic testing section has been removed from the policy. Please refer to the MVP Colorectal Cancer Susceptibility Genetic Testing medical policy. There is a Medicare Variation for coverage the following tests when medical policy criteria are met: Prolaris™, Decipher®, ConfirmMDx, Genomic Sequence Analysis Panel in the Treatment of Non-Small Cell Lung Cancer. Progenza® PCA3 Assay (Prostate Cancer Antigen 3) and ThyroSeq® v.2. have been added to the policy as investigational and therefore not covered for all products.

Investigational Procedures: Sacroiliac Joint Fusion for treatment of low back pain (Ifuse system) and Percutaneous Sacroplasty for sacral insufficiency were added to the policy. The policy was updated to

list percutaneous sacroplasty for treatment of sacral insufficiency fractures as investigational.

Hospital Inpatient Level of Care (NEW): This medical policy addresses determinations for inpatient level of care. The purpose of the policy is to assist with the complex considerations such as severity of illness, intensity of care needed, and individual member circumstances for determining inpatient level of care.

Obstructive Sleep Apnea, Surgical Treatment:

There are no changes to the medical policy criteria.

Oncotype DX Test: The following changes were made to the medical policy: Prosigna Breast Cancer Prognostic Gene Signature Assay for the assessment of risk recurrence in individuals with breast cancer is considered investigational and therefore not covered. A Medicare Variation for Oncotype DX Breast Cancer Assay, Oncotype DX Prostate Cancer Assay, and Oncotype DX Colon Cancer Assay was added to the policy. These tests are covered for Medicare products only.

Speech Generating Devices: The medical policy was updated with language to clarify those devices such as tablets or smartphones must be designed by the manufacturer to function solely as a speech generating device. The policy lists separately payable accessories for speech generating devices.

Ventricular Assist Devices (Left): There are no changes to the medical policy criteria.

Vertebroplasty and Vertebral Augmentation: Previously, the medical policy name was Vertebroplasty and Kyphoplasty. The policy is now called Vertebroplasty and Vertebral Augmentation. Percutaneous sacroplasty for treatment of sacral insufficiency fractures has been added to the policy as investigational and therefore not covered.

Medical Policies for Approval Without Changes in November 2016:

- Audiologic Screening (OAE)
- Compression Stockings
- Intraoperative Neurophysiologic Monitoring
- Interspinous Process Decompression System (IPD)
- Lymphedema Pumps, Compression, Garments, Appliances
- Neuropsychological Testing
- Radiofrequency Neuroablation Procedures for Chronic Pain

Clinical Guideline Updates

Careful Antibiotic Usage–Adult Treatment: MVP continues to endorse the guideline recommendations of the Center for Disease Control (CDC). The recommendations focus on preventing antibiotic resistance in adults. There have been no updates to the current guideline.

Careful Antibiotic Usage–Pediatric Treatment: The guideline addresses the growing problem of antibiotic resistance in children and follows the guideline recommendations of the Center for Disease Control (CDC). There have been no updates to the current guideline.

Childhood Preventive Care

MVP endorses the American Academy of Pediatrics' recommendations as well as the Centers for Disease Control (CDC) for immunization. There are few new updates/changes to the 2015 recommendations:

Vision Screening: Routine screening at age 18 has been changed to a risk assessment

Oral Health: Fluoride varnish is recommended from six months through five years

Adult Preventive Care

MVP has adopted Adult Preventive Care Guidelines.

The adult guidelines reflect recommendations by the US Preventive Services Task Force. There are few new recommendations for 2016/2017:

Obesity Screening and Counseling for Adults:

Screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.

Statin Preventive Medication: For adults ages 40–75 years with no history of CVD, one or more CVD risk factors, and a calculated 10-year CVD event risk of 10 percent or greater.

Tuberculosis Screening for Adults: Screening for latent tuberculosis infection in populations at increased risk.

Syphilis Screening for Non-pregnant Persons:

Screening for syphilis infection in persons who are at increased risk for infection.

Colorectal Cancer Screening: Screening for colorectal cancer starting at age 50 and continuing until age 75. See the USPSTF Clinical Considerations section for the various screening tests and the potential frequency of use.

Aspirin Preventive Medication: Adults age 50–59 with a ≥10 percent 10-year cardiovascular risk.

Pharmacy Updates

2017 Formulary Changes for Commercial and Marketplace Members

Formulary Exclusions: These medications will require medical exception approval.

2017 Commercial/Exchange Formulary Changes

Drug Class/Category	Excluded Drug	Preferred Drugs*
Anticoagulants	Pradaxa, Savaysa	Eliquis, Zarelto, warfarin
Antidepressants	Aplenzin	bupropion ER/XL/SR
	Parnate	tranylcypromine, phenelzine
Anxiety	Ativan	lorazepam, alprazolam, diazepam
Diabetes	Kombiglyze XR, Onglyza, Oseni, Kazano, alogliptan, alogliptan/metformin, alogliptan/pioglitazone	Tradjenta, Januvia, Janumet, Janumet XR, Jentadueto, Jentadueto XR
Erectile Dysfunction (Quantity limits still apply)	PCialis 10mg, 20mg (2.5mg and 5mg require prior authorization) Levitra, Staxyn, Stendra	Viagra

Drug Class/Category	Excluded Drug	Preferred Drugs*
Gastrointestinal	Gavilyte-H	Gavilyte-C, Gavilyte-G, Gavilyte-N
	Metozolv ODT	metoclopramide
	Zuplenz	ondansetron, ondansetron ODT
	Lotronex	alosetron
Muscle Spasm	Amrix	cyclobenzaprine, tizanidine
Respiratory	Incruse Ellipta, Tudorza, Alvesco, Aerospan	Spiriva Respimat/Handihaler, Combivent, Atrovent, Advair HFA/Diskus, Asmanex/HFA, Qvar, Symbicort
Seizure	Felbatol	Felbamate
	Mysoline	Primidone
Vitamins	Revesta	Folic acid and Vitamin D 50,000U

* No prior authorization required.

New Clinical Edits

Drug	Clinical Edits
Xifaxan 550mg	Prior authorization required
Syprine	Prior authorization required
Long acting oral stimulants (i.e., Adderall XR, Concerta, Ritalin LA, Vyvanse)	Quantity limit of one capsule per day

New Clinical Edits

Drug Class	Drug Name	Change
Diabetes	Toujeo Solostar	Tier 3 to Tier 2
	Tresiba FlexTouch	Tier 3 to Tier 2
Respiratory	Anoro Ellipta	Tier 3 to Tier 2
	Breo Ellipta	Tier 3 to Tier 2
	Flovent	Tier 3 PA to Tier 2 (no PA)

2017 Formulary Changes for Medicare Part D Members

This is not a complete list of changes, please refer to 2017 formulary document. For more information about the 2017 MVP Medicare Part D Formulary, visit mvphealthcare.com and select *Members*, then *Prescription Benefits*, and then *2017 Formularies*.

Non-Formulary Medications Requiring a Formulary Exception Request

Non-Formulary Medication	Formulary Alternatives
Nexium 20mg and 40mg capsules	Esomeprazole 20mg and 40mg capsules
Omeprazole/sodium bicarb capsules (generic Zegerid)	Esomeprazole, pantoprazole, lansoprazole, rabeprazole
Beconase, Omnaris, and Vermyst nasal sprays	Fluticasone, mometasone, and budesonide nasal sprays
Asacol HD, Uceris, Pentasa	Apriso, Delzicol, Lialda, balsalazide, mesalamine
Zioptan	Lumigan, Travatan Z

The following medications will now require prior authorization for Medicare Part D members for 2017:

- Lidocaine 5% ointment
- Xifaxan 550mg tablets

Office Administered Drugs for Medicare Members

For dates of service on or after January 1, 2017, medications ordered from the CVS Specialty Pharmacy and administered in the office for Medicare Advantage plan members will no longer be billed to the member's Part B benefit. If the drug is on the Medicare Part D formulary and you continue to obtain it through CVS Specialty Pharmacy, it will follow the utilization management requirements identified on the Medicare Part D formulary. Under the Part D benefit, the amount the member pays for the drug will change and drug cost will count toward the coverage gap. Please keep in mind that the amount the member pays for the medication may be more when billed under the Part D benefit.

Policy Updates Effective January 1, 2017

Crohn's Disease & Ulcerative Colitis, Select Agents: No changes to this policy.

Proton Pump Inhibitor Therapy: Omeprazole-sodium bicarb packets will require prior authorization. Brand Nexium and generic Zegerid removed from requirements for doses greater than allowed quantity.

Viberzi: New policy.

Enteral Therapy New York and Vermont: Promactin AA Plus added to list of products not requiring prior authorization. Clarified that medical foods are not covered.

Enteral Therapy New Hampshire: Policy archived.

Gaucher Disease Type 1 Treatment: Exclusions updated.

Pradaxa: Policy archived.

Hereditary Angioedema: Updated dosing of Ruconest.

Cuprimine: Policy achieved.

Chelating Agents: New Policy Cuprimine and Syprine will require prior authorization.

Hemophilia Factor: Coagadex, Adynovate, and Kovaltry added to policy.

Xifaxan: 550mg tablets will not require prior authorization.

Benlysta: No changes to this policy.

Select Hypnotics: Generic Intermezzo must meet step edit requirements.

Gralise: No changes to this policy.

Multiple Sclerosis Agents: EDSS criteria removed from policy.

Oral Allergen Immunotherapy Medications: No changes to this policy.

Weight Loss Agents: Saxenda will require failure of Belviq and Contrave.

Xyrem: Failure of methylphenidate added to excessive daytime sleepiness criteria.

Respiratory Syncytial Virus/Synagis: Medicaid variation updated.

Immunoglobulin Therapy: Hemolytic uremic syndrome removed from criteria.

Addyi: New policy.

Pain Medications: Criteria for opioid point-of-sale edits added to policy.

Formulary Updated for Commercial, Marketplace, and Medicaid Formularies

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

Drug Name	Indication
Afstyla	Hemophilia A
Epclusa	Hepatitis C
Zinbryta	MS
Vonvendi	Von Willebrand disease
Xiidra	Dry eyes
Bevespi Aerosphere	COPD
Byvalson	Hypertension
Qbrelis	MI
Zurampic	Gout
Sustol	N/V due to chemotherapy
Otovel	Otitis media
Exondys 51	DMD
Cuvitru	Immunodeficiency
Taytulla	Acne vulgaris
Kyleena	Contraception

Drugs Added to Formulary

Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace

Aripiprazole ODT	Ethacrynic acid
Nilutamide	Olmesartan-amlodipine
Olmesartan/HCT	Yuvaferm

Drugs Removed from Prior Authorization

Alecensa	Bendeka
Darzalex	Descovy
Iressa	Odefsey
Otiprio	Portazza
Propel Implant	Seebri Neohaler
Utibron Neohaler	Vistogard



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MVP Provider Directory

You can search the current MVP Provider Network at www.mvphealthcare.com. Select *Find a Doctor* to search for current primary care providers and specialists online.



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.

Contacting MVP Professional Relations

MVP Corporate Headquarters	1-888-363-9485
Southern Tier	1-800-688-0379
Central New York	1-800-888-9635
Midstate	1-800-568-3668
Mid-Hudson	1-800-666-1762
Buffalo and Rochester	1-800-684-9286
Vermont	1-800-380-3530

Denise V. Gonick
President & CEO

We welcome your comments.

Healthy Practices
MVP Health Care, Inc.
Professional Relations Dept.
PO Box 2207
Schenectady, NY 12301



PROFESSIONAL RELATIONS UPDATES

New for 2017: Telemedicine Benefit

MVP Health Care will cover “direct-to-consumer” telemedicine—we’re calling it **24/7 online doctor visits**—beginning January 1, 2017, subject to regulatory restrictions and approval. We will cover two main types of visits, urgent care and behavioral health, as well as ancillary services such as nutrition and lactation consultations. We are including the telemedicine benefit in all of our fully insured, Medicare, Medicaid, and Essential plans upon renewal starting January 1, 2017. Our ASO groups will have the option of adding the telemedicine benefit to their coverage, also. The only exceptions will be members in Vermont Small Group and Individual plans, who will receive this benefit in 2018 upon renewal, subject to regulatory restrictions and approval.

We see this as an opportunity to evolve patient care for our members. With the telemedicine benefit, our members will be able to see a health care provider for urgent care anytime, day or night, via a mobile device or a computer with a webcam. (Other types of online consultations will be available with extended hours, but not overnight.) It could be an MD, it could be a behavioral health practitioner, a dietician, or a lactation consultant...this is about giving our members a convenient new way to access health care.

Telemedicine is not meant to replace the very valuable PCP relationship, or other in-person provider visits. From a cost perspective, while online visits will be less expensive than urgent care or low-acuity ER visits, the cost-share for members who use this benefit will not be lower than a PCP visit. Again, this is about giving our members more options and greater access to care.

We think it’s a great benefit for busy families, for those with limited mobility, and for patients who may be incapacitated for any number of reasons. Telemedicine will enable them all to access health care from the comfort of their home.

(Continued on page 2)

A New Look for the MVP Website

The MVP website homepage and content for our customers and partners—members, employers, brokers, and health care providers—have a bold new look. We also have streamlined and organized the resources we have online for you so that it’s easy to find the answers and support you need. Visit mvphealthcare.com and select *Providers* at the top of the redesigned homepage for access to content and alerts, or *log in* to your account. The features available to you post login have remained unchanged.

(Telemedicine Benefit continued from page 1)

The telemedicine benefit will be especially valuable for behavioral health care. Talking to a behavioral health practitioner from home can make a huge difference for our members, not just in their comfort level, but also by removing a possible reason to skip treatment.

Following are answers to what we anticipate are your most pressing questions about the new telemedicine benefit.

Q: Who are MVP's partners in bringing this telemedicine benefit to MVP members?

A: MVP is working with American Well, a leading telehealth technology platform, and the Online Care Group (OCG), the American Well affiliated virtual provider group.

Q: Who will have access to this?

A: MVP will be including this benefit in our fully-insured plans upon renewal, beginning January 1, 2017. (Note: members of fully-insured Vermont Small Group and Individual plans will receive this benefit upon renewal beginning January 1, 2018.)

MVP will also be including this benefit in Medicare, Medicaid, and Essential Plans, upon renewal, beginning January 1, 2017. (Note: SmartFundSM MSA and RxCare PDP members will not receive this benefit.)

Self-funded (ASO) groups may choose to add this benefit beginning January 1, 2017.

Q: What can it be used for?

A: MVP members can access non-emergency care online, keeping in mind that it's not intended to replace their Primary Care Physician (PCP). The most common urgent care and behavioral health diagnoses include: sinusitis, upper respiratory infections/flu, pharyngitis, skin disorders, urinary tract infection, bronchitis, conjunctivitis, earache, back pain, stress, mood disorders, insomnia, and eating disorders.

Q: How is this different from the 24/7 Nurse Advice Line service offered by MVP?

A: A call to the 24/7 Nurse Advice Line will connect a member to a nurse for information and advice. The registered nurses often help a member decide on a course of action (go to the ER, urgent care center, their regular doctor, or treat at home). A telemedicine visit is an online visit with an actual doctor or other health care provider who can give a diagnosis, treatment, and in some cases, a prescription.

Q: What is the Online Care Group network of health care professionals?

A: We are inviting MVP-participating health care providers to join an already well-established and reputable national network (the Online Care Group, or OCG) to provide these services. Here are some other facts about the network:

- National, telehealth-only physician network
- Employed physicians, not a call center
- Board-certified, multi-state licensure
- Credentialed to NCQA/URAC standards
- 24/7/365 availability
- Average wait time is less than six minutes

Behavioral Health Facts

- Over 400 network providers
- Services can be accessed via web-based computer, tablet, or mobile device
- Access standard goals are seven days from request for therapy/counseling services (appointments available seven days per week, 7 am–11 pm in each time zone)
- Therapy/counseling services are currently available within one day of request
- Self-scheduling feature

Q: What types of health care professionals will an MVP member be able to connect with online?

A: For urgent care: emergency medical primary and family physicians, and pediatricians

For behavioral health: licensed social workers and PhD-level psychologists

For nutrition and wellness: registered dietitians and lactation consultants

Q: What standards are in place to ensure MVP members will see highly-qualified health care professionals?

A: Clinical services will be provided by OCG, the nation's first and largest primary care group devoted to telehealth. In addition to being able to see health care providers who are already part of the MVP network (those who choose to also participate with OCG).

All health care professionals in OCG:

- Have an average 15 years of experience in primary and urgent care
- Are U.S. board-certified, licensed, and credentialed
- Have profiles, so you can see their education and practice experience

(Continued on page 3)

(Telemedicine Benefit continued from page 2)

- Are rated by other patients, so you can review and select the doctor that meets your needs

Q: How can an MVP-participating provider join OCG and offer online visits to MVP members?

A: MVP providers may contact American Well directly to begin the process of joining OCG.

- Visit **americanwell.com** and select *Group Practices*, and then *Join Online Care Group* for information
- Providers may email a CV to **ocg.recruiting@americanwell.com**

OCG handles credentialing and training:

- Providers complete an online application and background check
- Once submitted, the approval takes 4–6 weeks
- While waiting for approval, providers complete self-paced eLearning
- Once approved, providers complete a “certification” session, which is a mock patient visit

Q: Can an MVP provider choose to see only his/her patients, is it limited to MVP members, or will they be scheduling online doctor visits with anyone, anywhere?

A: We are inviting MVP-participating providers to take part in the telemedicine program (by joining OCG). If you choose to participate and you are seeing patients at the time they start an online visit, they can connect with you by using the search feature they will see when they log in online.

At this time, MVP providers who join OCG do not have the option to choose to see only their patients. Provider participation in OCG is strictly voluntary with the understanding that patients may or may not be MVP members.

In the future, local provider groups may be able to set up their own private practices on this platform. We will provide more information and requirements for groups interested in this as details emerge.

Q: Is there any risk to a provider’s quality and performance rates if his/her MVP patients use the telemedicine benefit instead of going into a provider’s office?

A: Telemedicine visits will generally impact a physician’s quality scores in the same way that their patient’s use of brick-and-mortar urgent care centers might (they may be excluded from some measures), meaning that telemedicine can have both positive and negative effects. MVP has reviewed the possible impact on various measures

and it appears that, overall, the effect should be neutral or slightly positive.

Q: How can Primary Care Physicians (PCP) receive copies of summaries from a telemedicine visit?

A: There are different ways that PCPs can receive copies of the visit summary:

- First, members will always have the ability to access, print, and download visit summaries to share with their PCPs.
- Second, a member may input their PCP’s email address at the time of the visit to have a summary sent via email afterward.
- Finally, a member may authorize MVP to send the visit summary to their PCP. This requires the member to have up-to-date PCP information in their MVP online account, and for MVP to have their PCP’s email address on file.

Medicaid Expansion

MVP Health Care began offering Medicaid Managed Care and Child Health Plus in six new counties on October 1, 2016. The counties are Columbia, Greene, Lewis, Oneida, Putnam, and Washington. MVP will also offer the Essential Plan in all of these counties except Putnam.

It is all part of MVP’s commitment to offering low or no-cost coverage across New York State. MVP is also committed to educating all members about the available plan benefits. These include regular checkups, dental and vision care, emergency treatment, and much more.

Residents of these counties can apply for coverage through MVP on the NY State of Health™ Marketplace at **nystateofhealth.ny.gov**. They can also call the MVP Customer Care Center at **1-800-852-7826**, Monday–Friday, 8:30 am–5 pm, to speak with an MVP Representative who can help with the application.

MVP Member ID Cards

MVP continuously seeks to improve our business processes. We are excited to announce that beginning in January 2017, MVP will launch a newly designed Member ID card for our Commercial, Medicaid, and Medicare members. The 2017 ID card templates feature more clearly organized member and provider information and a new design element in an effort to make health care simpler for our members, providers, and employer groups.

Changes on Commercial ID Cards

- Simplified member information
- Prominently called-out plan name

- Brand element
- Rx Group, Rx Bin, and PCN on front of the card

Changes on Medicare ID Cards

The Medicare cards will have a newly designed front with a larger font size for the information members may need to reference, such as their ID number, co-pays, and contact information on the back of the card, making everything easier to read.

Changes on the Medicaid ID Cards

The Medicaid cards will also have a newly designed front and contact information on the back of the card that is separated by *For Members* and *For Providers* sub-headings to clearly identify the appropriate contact information for users.

For further information concerning all new designed ID card samples, please visit our 2017 Provider Manual Resource on or after January 1, 2017.

New Participating Provider Enrollment Toolkit

MVP is committed to offering the highest-quality health care to our members. We do that by aligning with the best health care practitioners. In an effort to improve MVP's credentialing and registration process for providers, we are in the process of creating a step-by-step guide to walk you through the most appropriate process to becoming an MVP participating provider. The new toolkit will be available in print for providers in the coming weeks and will be posted on-line in the next couple months. This will help providers determine which process they should follow, provide them with a checklist of required information, and all the required forms they will need to move through the process quickly and efficiently.

Watch for more information regarding this exciting new development that will help simplify the credentialing and registration process with MVP.

MVP Annual Notices

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 MVP's 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 MVP's annual notices for health care providers, visit **mvphealthcare.com** and select *Privacy & Compliance* at the bottom of the homepage. If you would like to receive a printed copy of this information, please call Professional Relations at the phone number shown on the front page of this newsletter.

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, or address, phone number, or tax ID number changes.

To report demographic changes to MVP, please complete a Provider Demographic Change form. To download the form, visit **www.mvphealthcare.com** and select *Providers*, then *Forms*, and then the appropriate form under *Provider Demographic Change Forms*. Please return the completed demographic change form on letterhead to the appropriate fax number or email below.

East New York and Massachusetts

518-836-3278

eastpr@mvphealthcare.com

Central, Mid-State, or Southern Tier New York

315-736-7002

centralprdept@mvphealthcare.com

Rochester

585-327-5747

RocProviderChanges@mvphealthcare.com

Mid-Hudson New York
914-372-2035
MidHudsonprdept@mvphealthcare.com

Vermont
802-264-6555
vpr@mvphealthcare.com

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

QUALITY IMPROVEMENT UPDATES

Marketplace (Exchange) Primary Care Improvement Program Coming January 2017

In an effort to improve the quality of care our Marketplace (Exchange) members receive, MVP is offering a new provider incentive program for the following HEDIS measures:

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Adolescent Well-Care Visits
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years
- Well-Child Visits in the First 15 Months of Life
- Immunizations for Adolescents
- Comprehensive Diabetes Care
- Medication Management for People with Asthma
- Annual Monitoring for Patients on Persistent Medications

More details on this incentive program will be distributed in December 2016.

HEDIS/QARR and CAHPS Measure Spotlight

HEDIS (Healthcare Effectiveness Data & Information Set) is a nationally recognized set of healthcare 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. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks members to evaluate their experiences with health care via a survey tool. MVP monitors its performance in these measures on an ongoing basis and submits results to NCQA annually.

The state and federal government also monitor these 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 state QARR (Quality Assurance Reporting Requirements) programs are two examples.

Information on Select HEDIS and CAHPS Measures

(CBP) Controlling High Blood Pressure

Compliance is achieved when individuals with a diagnosis of hypertension (HTN) meet the following criteria:

- Members 18–59 years of age whose blood pressure is <140/90 mmHg.
- Members 60–85 years of age with a diagnosis of diabetes whose blood pressure is <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose blood pressure is <150/90 mm Hg.

Chart documentation of compliant blood pressure readings accepted by HEDIS includes:

- Both a systolic and diastolic reading within the above parameters.
- Blood pressure reading must be exact, no rounding up or down.
- Documentation of a Hypertension diagnosis* with the blood pressure readings following the date of diagnosis.

**Documentation of a hypertension diagnosis must be found in the chart on or before June 30 of the measurement year.*

(SMD) Diabetes Monitoring for People with Diabetes and Schizophrenia

This measure focuses on members with a diagnosis of diabetes and schizophrenia between the ages of 18 and 64. Compliance is achieved when the member has BOTH a Hemoglobin A1c (HbA1c) test AND an LDL-C test performed during the measurement year.

Note: evidence of the HbA1c and LDL-C tests must be obtained from claim/encounter or automated laboratory data, NOT chart review.

(SAA) Adherence to Antipsychotic Medications for Individuals With Schizophrenia

This measure focuses on medication adherence for anti-psychotics for members ages 19–64 with schizophrenia. Compliance is met if individuals were dispensed an anti-psychotic and remained on it for at least 80 percent of their treatment period. The treatment period starts on the date the initial prescription was filled and concludes on the last day of the measurement year.

Note: evidence for this measure must be obtained from claim/encounter data, NOT chart review.

(CAHPS) CAHPS Composite Measure: Shared Decision Making

The shared decision making questions are asked of members who indicated on the survey that their doctor discussed starting or stopping a prescription medication within the last 12 months. Compliance is met if the member answers “yes” to the following:

- Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
- Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?
- When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

Major Changes for HEDIS 2017!

Two measures have had significant changes/clarifications from the last HEDIS reporting year that we wanted to make you aware of:

Immunizations for Adolescents (IMA): The HPV vaccine has been added as a requirement for this measure. Previously this measure focused on adolescents receiving one dose of meningococcal conjugate vaccine and one dose of Tdap by their thirteenth birthday. Now this measure also requires three doses of HPV vaccine by age 13 (for both boys and girls).

Breast Cancer Screening (BCS): NCQA clarified that this measure does not count diagnostic screenings as a “pass”. The intent of this measure is to evaluate primary screenings. Diagnostic screenings, biopsies, ultrasounds, and MRIs do not count toward this measure as they are not considered appropriate methods for primary breast cancer screening.

Colorectal Cancer Screening (COL): Following the recent release of updated guidelines from the USPSTF for colorectal cancer screening, NCQA has added additional tests that may count for this measure:

- CT colonography during the measurement year or the four years prior to the measurement year. Please note: MVP does not cover CT colonography when used for screening. This is consistent with CMS guidance.
- FIT-DNA test during the measurement year or the two years prior to the measurement year.

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 and tips available to support your work—some of these are described below:

Controlling High Blood Pressure Measure

- Educate patients on the importance of exercise, low-sodium diet, and quitting smoking to control blood pressure.
- If appropriate, prescribe medication to lower blood pressure. Refer to MVP’s guidelines which are based on the 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC8). A copy of the JNC 8 can be found at jamanetwork.com/journals/jama/fullarticle/1791497.
- For those on anti-hypertensives, remind them about the importance of taking medication as prescribed and reporting any side-effects. Schedule regular follow-up visits to ensure medications are working appropriately and make adjustments as needed.
- During the office visit be sure to take the blood pressure reading more than once. If it was high at the beginning of the visit re-take it at the end of the visit and be sure to document both readings.

Schizophrenia Measures

People with schizophrenia or bipolar disorder who also have diabetes have a higher mortality rate than those with diabetes alone. These individuals need close monitoring by both their behavioral health specialist and primary care provider to ensure they are taking their medications as prescribed and obtaining the appropriate diabetes testing. Key points to remember when working with these patients:

- Educate patients on the importance of medication adherence. Reach out to their prescribing behavioral health provider if patient complains of issues such as side effects interfering with their ability to take the medication.
- Educate patients with diabetes on their increased risk of heart disease and about the importance of regular HbA1c testing and LDL-C testing. Follow through with patient to determine if they had their testing done (if blood not drawn in office).
- Do not rely on the patient to following through with scheduling appointments. Ensure they have a follow-up scheduled before leaving the office.

If an appointment is missed have office staff call to assess why and re-schedule.

- Keep an open line of communication with their behavioral health provider. Ensure they have a complete overview of the member's health issues and concerns and work together to coordinate any medications the member is prescribed. Communication and coordination among providers is essential to help reduce medical errors and improve quality, safety, and continuity of care.
- Work with MVP's Case Management Department and/or MVP's behavioral health partner, Beacon Health Options, for members with diabetes and schizophrenia to identify appropriate members for outreach. Case Managers can work with the member over the phone to provide education to assist in the management of their diabetes, ensure they are getting the appropriate testing for diabetes, are adhering to prescribed medications, and following up with their appointments. To refer a member, please call **1-866-942-7966** for more information.
- Beacon Health Options also has "PCP Toolkit" that provides general information about Beacon support for PCPs in addressing behavioral health issues. To access the toolkit, visit **beaconhealthstrategies.com** and select *Providers*, and then *PCP Toolkit*.

CAHPS Measures

- Communicate with patients thoroughly and in a manner they understand.
- When starting a new medication, be sure to talk to your patients about the benefits and risks of taking the medication.
- If discontinuing a medication, let the patient know the reasons why.
- Let the patient share in the decision-making regarding treatment. Ask them for their opinion about what is best for them.
- Allow time for them to ask questions and verify that they understand.
- Review your Accountable Care Metric (ACM) report that MVP produces annually. The ACM report includes CAHPS measures. Three composites are reported: Getting Care Quickly, Care Coordination, and Communicate Well. This report depicts the practices rate for each measure, compared to the health plan rate. Results are taken into consideration in MVP's Pay for Performance (P4P) program. They are delivered 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** at **mfarina@mvphealthcare.com**.

¹Vinogradova, Y., C. Coupland, J. Hippisley-Cox, S. Whyte, C. Penny. 2010. "Effects of Severe Mental Illness on Survival of People with Diabetes." *British Journal of Psychiatry* 197:272-7. Accessed September 26, 2016 at: <http://bjp.rcpsych.org/content/197/4/272.long>.

CARING FOR OLDER ADULTS

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Medicare Wellness Visits and New Incentive Program

MVP would like to remind providers that MVP Medicare Advantage plan members are entitled to and are encouraged to have a Welcome to Medicare or Annual Wellness Visit (as defined by Medicare) with their doctor. During this visit, you and the patient should develop or update a personal health plan based on the patient's current health and risk factors, and complete a Health Risk Assessment. Answering these questions can help you and the patient develop a prevention plan for staying healthy and getting the most out of the visit. There are three codes that can be billed for these visits: G0402 (Welcome to Medicare—first 12 months in Medicare), G0438 (initial Annual Wellness Visit), and G0439 (subsequent Annual Wellness Visits). For more information, visit **cms.gov** and *search* for "The ABCs of the Initial Preventive Physical Examination (IPPE)" and "The ABCs of the Annual Wellness Visit (AWV)" education materials.

Starting January 1, 2017, participating in these visits is the first step for MVP Medicare members to earn a Wellness Rewards incentive for completing select preventive services. Members will ask the provider to complete and sign a form confirming they have had a Welcome to Medicare or Annual Wellness Visit, a colorectal cancer screening within the recommended Medicare guidelines, and a flu shot for the current flu season. Members are responsible for submitting the information to MVP to receive their reward of a \$75 gift card.

MEDICAL POLICY UPDATES

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The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the June 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 *Benefit Interpretation Manual* (BIM) located on mvphealthcare.com. To access the BIM, log in to your account and select *Online Resources*, then *BIM* under *Policies*. 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 Professional Relations representative.

Medical Policy Updates Effective December 1, 2016

Autologous Chondrocyte Implantation, Osteochondral Allograft Transplantation, Osteochondral Autograft Transfer System (OATS):

Now covered when medical policy criteria are met. Previously these three procedures were not covered.

Bariatric Surgery: The policy was updated with criteria for subsequent or repeat bariatric surgeries. Previously, these were an exception and a limit of one procedure per lifetime per patient.

Bone Density Study for Osteoporosis (DEXA): There are no changes to the medical policy criteria.

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

Bronchial Thermoplasty: There are no changes to the medical policy criteria. Bronchial thermoplasty remains a non-covered procedure.

Cosmetic and Reconstructive Services: There are no changes to the medical policy criteria.

Dental Care Services Facility Services: There are no changes to the medical policy criteria.

Dermabrasion: There are no changes to the medical policy criteria.

Durable Medical Equipment: MVP follows Medicare criteria and guidelines.

Early Childhood Disorders (VT): There are no changes to the medical policy criteria.

Gender Reassignment: The Gender Reassignment medical policy has been updated with the following Medicaid requirements: The requirement that a member be over 21 was removed and signing of form for procedure resulting in sterilization was removed. Letters are required from New York State licensed mental health professionals and are now allowed from a New York certified psychiatric nurse practitioner. Conversion therapy has been added to the exclusions section as not covered.

Hospice Care: There are no changes to the medical policy criteria.

Home Care Services: There are no changes to the medical policy criteria.

Hyperbaric Oxygen Therapy (HBO): There are no changes to the medical policy criteria.

Indirect Handheld Calorimeter: There are no changes to the medical policy criteria.

Inpatient Skilled Nursing Facility (SNF) Services for Medicare Products Only: **NEW POLICY** The policy follows Medicare criteria for inpatient SNF coverage. For full Medicare language and criteria please refer to the link listed in the medical policy.

Insulin Infusion Pumps: The Insulin Infusion Pumps Policy includes criteria from Interqual, Medicare, American Diabetes Association, and American Association of Endocrinologists. A Medicare exclusion was added in regards to OmniPod disposable drug delivery system, which is not covered for Medicare members.

Investigational Procedures: Sacroiliac Joint Fusion for treatment of low back pain (Ifuse system) and Percutaneous Sacroplasty for sacral insufficiency were added to the policy. Both Sacroiliac Joint Fusion and Percutaneous Sacroplasty are not covered as they are considered investigational.

InterQual Criteria Medical Policies: There is a Medicare variation for spinal cord stimulators which can be used to treat chronic intractable pain.

Knee Arthroscopy: **ARCHIVED** This policy will be archived effective December 1, 2016.

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

Prosthetic Devices Eye and Facial: There are no changes to the medical policy criteria.

Repetitive Transcranial Magnetic Stimulation (rTMS): This policy now follows Beacon Health criteria. rTMS services are reviewed by Beacon Health and Primarilink.

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

Medical Policies for Approval Without Changes in August and September 2016

- Artificial Intervertebral Discs-Cervical and Lumbar
- Autism Spectrum Disorders NH
- Breast Reduction Surgery
- Endoscopy/Colonoscopy
- Endovascular Repair of Aortic Aneurism
- Endovenous Ablation of Varicose Veins
- Laser Treatment of Port Wine Stains
- Low Vision Aids
- Oxygen Therapy for the Treatment of Cluster Headaches
- Personal Care and Consumer Directed Services
- Umbilical Cord Blood Banking

Medical Policy Updates Effective December 1, 2016

Amniotic Membrane Transplant for the Treatment of Ocular Conditions: CPT Codes 65778, 65779, 65780, and HCPCS Code V2790 will not require prior authorization effective January 1, 2017.

Capsule Endoscopy: CPT Codes: 91110, 91111, and 91112 will not require prior authorization effective January 1, 2017.

CT Modifier Claim Payment Reduction Notification

MVP is changing how the technical component fees are paid for radiology claims billed with a CT modifier for all lines of business. This change will be effective for January 1, 2017 and subsequent dates of service.

The CT modifier must be used when claims are billed for non-NEMA Standard XR-29-2013 compliant CT scans. CPT codes affected by this change are: 70450-70498; 71250-71275; 72125-72133; 72191-72194; 73200-73206; 73700-73706; 74150-74178; 74261-74263; and 75571-75574. The technical component payment of global procedures billed with the CT modifier will be reduced by 15 percent. Claims billed with the TC and CT modifier and paid per the CMS provider fee schedule/OPPS will be reduced by 15 percent.

More information is available by logging into your account at mvphealthcare.com and selecting *MVP Provider Resource Manual* under *Online Resources*. Please refer to Section 15: Payment Policies, Modifier policy.

PHARMACY UPDATES

Pharmacy Medicaid Opioid Edits

Effective October 1, 2016, New York Medicaid Managed Care Members:

- Will only be allowed a maximum of four prescriptions of opioid analgesics in a rolling 30-day period. A clinical prior authorization will be required for prescriptions of opioid analgesics in excess of four prescriptions in a rolling 30-day period.
- Will only be allowed a seven-day supply starter dose for each new prescription of immediate release opioid analgesics.
- Will not be allowed to fill an opioid analgesic if the member has filled buprenorphine (i.e., Suboxone, buprenorphine/naloxone, buprenorphine SL, etc.) within the past 60 days.

Medicaid Mosquito Repellent Coverage

Effective September 1, 2016, MVP will provide coverage for mosquito repellent when prescribed to Medicaid enrollees, with a valid prescription order, who intend to travel to, or return from a Centers of Disease Control (CDC)-recognized area of localized Zika transmission.

New York Commercial/Exchange Opioid Edit

Effective October 20, 2016, members will only be allowed a seven-day supply starter dose for each new prescription of immediate release opioid analgesics.

Medicare Diabetic Test Strips

MVP prefers OneTouch, Freestyle, and Precision diabetic test strips for Medicare members. Effective January 1, 2017, MVP will require prior authorization for all non-preferred diabetic test strips. Members can receive a new preferred meter free of charge if they are currently using a non-preferred meter. Members can contact the MVP Customer Care Center at the number on the back of their Member ID card for more details on obtaining a new preferred meter.

Office Administered Drugs for Medicare Members

Beginning January 1, 2017, medications ordered from the CVS Specialty Pharmacy and administered in the office for Medicare Advantage plan patients will no longer be billed to the patient's Part B benefit, these drugs will be covered under the patient's

Part D prescription drug benefit. Examples of these medications include Prolia, Xolair, Xgeva, Lucentis, and Eylea. Under the Part D benefit, the amount the patient pays for the drug will change and drug cost will count toward the coverage gap.

**Pharmacy Policy Updates
Effective January 1, 2017**

Crohn’s Disease and Ulcerative Colitis, Select Agents

- No changes

Proton Pump Inhibitor Therapy

- Omeprazole-sodium bicarbonate packets will require prior authorization

Viberzi

- New policy

Enteral Therapy New York and Enteral Therapy Vermont

- Medical foods are not covered
- Promactin AA Plus will not require prior authorization

Enteral Therapy New Hampshire

- Policy archived

Gaucher Disease Type 1 Treatment

- Exclusions updated

Pradaxa

- Policy archived

Hereditary Angioedema

- Updated recommended dosing of Ruconest

Cuprimine

- Policy name changed to Chelating Agents
- Syprine will require prior authorization

Hemophilia Factor

- Coagadex, Adynovate, and Kovaltry added to policy

Xifaxan

- 550mg will require prior authorization

Formulary Updates for Commercial, Medicaid, and Marketplace Formularies

New Drugs (recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid)

Drug Name	Indication
Afstyla	Hemophilia A
Epclusa-tier 2 for Commercial and Medicaid	Hepatitis C GT-1, 2, 3, 4, 5, or 6

Zinbryta	MS
Vonvendi	Von Willebrand Disease
Xiidra	Dry eye disease
Drug Name	Indication
Bevespi Aerosphere	COPD
Prednisolone-moxiflox-ketorolac ophthalmic solution	Bacterial conjunctivitis
Byvalson	HTN
Obrelis	CHF, MI

Drugs Added to Formulary (Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace)

Nilutamide	Aripiprazole ODT
Ethacrynic acid	

Drugs Removed from Prior Authorization

Iressa	Darzalex
Portrazza	Alecensa
Bendeka	Propel Implant
Seebri Neohaler	Utibron Neohaler

**2017 Formulary Changes
Effective January 1, 2017**

The following drugs will be moving from Tier 3 to Tier 2 on the Commercial and Exchange Formularies:

Anoro Ellipta
Breo Ellipta
Flovent-PA will also be removed
Toujeo
Tresiba



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MVP Provider Directory

You can search the current MVP Provider Network at www.mvphealthcare.com. Select *Find a Doctor* to search for current primary care providers and specialists online.



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.

Contacting MVP Professional Relations

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

Denise V. Gonick
President & CEO

We welcome your comments.

Healthy Practices
MVP Health Care, Inc.
Professional Relations Dept.
PO Box 2207
Schenectady, NY 12301



www.mvphealthcare.com

PROFESSIONAL RELATIONS UPDATES

MVP Health Care Appoints New Chief Medical Officer

MVP Health Care has named Elizabeth (Beth) Malko, M.D. as its new chief medical officer. Dr. Malko succeeds Allen Hinkle, M.D., who announced earlier this year that he would be leaving MVP.

Dr. Malko has more than 20 years of managed care experience, bringing her medical expertise to both for-profit and not-for-profit payor settings. She comes to MVP from a position as executive vice president for clinical transformation and operations at Evolent Health in Arlington, Va. Evolent was founded in 2011 by The Advisory Board to help progressive health care systems lead, build, and own the path to value-based care.

She has extensive management experience, including leadership of engineers, physicians, pharmacists, nurses, and administrative and managed care staff. She led a staff of more than 350 associates at Evolent in clinical strategy and relationships. Previously, Dr. Malko served as the executive vice president and chief medical officer for Fallon Community Health Plan in Worcester, Mass.; as the regional medical director for WellPoint Inc.'s state-sponsored business; and as a lead medical director for Anthem BCBS in New Hampshire and Connecticut. Earlier in her career, she also served as a family physician in private practice and as a chief engineer in several environmental engineering firms.

"Dr. Malko brings great talent and experience to MVP and I am confident that she will play a significant role in our ongoing transformation as we meet and manage the challenges presented by an ever-changing industry," said MVP President and CEO Denise Gonick.

Dr. Malko earned a B.S. degree in biology and a master's degree in engineering and environmental engineering from Rensselaer Polytechnic Institute. Her M.D. was awarded by the University of Connecticut. She was board certified in family practice and is an active fellow of the American Academy of Family Practice.

Smoking Cessation— An Intervention Whose Time Is Here

Recent data has shown a reduction in tobacco smoking over the past several years. However, many of your patients, including teenagers, continue to smoke. Helping them to quit may be the most important thing you can do for them. Medical literature clearly supports the importance of physician

(Continued on page 2)

intervention in getting patients to quit and new programs are available to assist in accomplishing this goal.

There are many barriers to getting a smoker to quit. One problem is that many of the ads and brochures focus on complications of smoking that will not occur until later in life. Teenagers and twenty-somethings are notorious for their sense of invincibility and a lack of concern for what may happen in the far future. It is important when communicating with them to point out the more immediate effects that may impact them sooner. This includes the effects of smoking on appearance, such as stained teeth and yellow fingers, and increased susceptibility to infections, such as pneumonia. It also increases the risk of Type 2 diabetes and may lead to an increased rate of progression in individuals with Type 2 diabetes.

Another factor that may catch the attention of younger smokers is the effect of vasoconstriction on sexual function and fertility. Smoking contributes to the rise of impotence in men and to reduced responsiveness and achievement of orgasm in both men and women. In addition, it may contribute to infertility in women and can increase the risk of preterm birth, birth defects, and low birth weight during pregnancy and the risk of otitis, respiratory infections and Sudden Infant Death Syndrome (SIDS) in newborns and infants.

The longer term effects, which may bear mentioning, include increased risk of lung disease, heart disease and stroke as well as many types of cancers, including lung, throat, head and neck, colorectal, cervical, blood, pancreas, and kidney. If the risk of lung cancer is not enough to get their attention, maybe the long list of cancers will. It may also help to mention that the risk of dying is three times higher in smokers.

Advise your patients that free support is available by phone or online from the New York State Smokers' Quitline at **1-866-NY-QUITS** (1-866-697-8487), or **www.nysmokefree.com**. MVP Health Care wants to help you to keep your patients healthy.

MVP Survey Appreciation Award Winners

The following Provider Offices are the winners of the four \$50 VISA cards winners from the Provider Utilization Management survey:

Pre-Emption Family Medicine	Penn Yan, NY
HRHCare	Hudson, NY
St. Peter's Sleep Center	Albany, NY
Jacques Piche, MD	Plattsburgh, NY

Home and Community Based Services (HCBS)

As of October 1, 2016, MVP will begin offering the following Home and Community Based Services to eligible MVP Harmonious Health Care Plan members:

Psychosocial Rehabilitation Services

Psychosocial Rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., substance use disorder and/or mental health).

Community Psychiatric Support and Treatment

Community Psychiatric Support and Treatment (CPST) includes time-limited, goal directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan.

Empowerment Services–Peer Supports

Peer Support services are peer-delivered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing behavioral health symptoms.

Habilitation

Habilitation services are typically provided on a one-on-one basis and are designed to assist participants with a behavioral health diagnosis in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources, and adaptive skills necessary to reside successfully in home and community based settings.

Respite

Short-term crisis respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life.

Intensive crisis respite is a short-term, residential care, and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms.

Family Support and Training

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process, and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

Non-Medical Transportation Services

Non-medical transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan.

Individual Employment Support Services

Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self employment arrangement.

Education Support Services

Education support services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment.

For additional information about these services, visit www.omh.ny.gov and select *Consumers & Families*, then *Behavioral Health Managed Care*, then *Managed Care Updates*, then *Overview*, and then *Health and Recovery Plans (HARP)*.

Introducing Our New Notification System Focusing on Authorizations

MVP Health Care is announcing the launch of our new online notification system on the MVP Provider Portal. If you elect, you will begin to receive an email notification for the following types of authorization letters:

- Approval letters
- Request for information letters
- Partial approval letters
- Denial letters

MVP will provide more information about this new program soon, including contact and resource information that will advise as to how you can start accessing this new online feature, on and after September 9, 2016.

Online Provider Demographic Information Review Request

The Centers for Medicare and Medicaid Services (CMS) regulation 42 CFR 422.111(b)(3) and (h)(2)(ii), 422.112, 423.128(d)(2) requires that all health plans

work with their provider network on a quarterly basis to confirm the provider demographic information in the online directory is accurate. Providers are required to review their demographic information in the MVP directory and notify MVP of any inaccuracies in the directory to be updated.

MVP is asking all participating providers to follow these steps:

Step 1: Visit www.mvphealthcare.com and select *Find a Doctor*, then *Search by Provider*.

Step 2: Search for the provider(s) in your practice and review the following demographic information for accuracy:

- Ability to accept new patients
- Street address or missing addresses
- Phone number
- Other changes that affect availability to patients. (e.g. handicap accessible, specialty changes)

Step 3: If demographic information is identified as incorrect, please submit the correct information to MVP using the *MVP Providers Change of Information* form. To download this form, visit www.mvphealthcare.com and select *Providers*, then *Forms*. Delegated providers should contact their delegate administrator to update demographic information.

Step 4: If the update applies to multiple providers in the group, please include a roster of all providers to whom the change applies, including the providers name and NPI, when you submit updates to MVP.

Step 5: Fax or email the completed *Providers Change of Information* form to the appropriate regional fax or email address listed on the form.

Step 6: *Login* at www.caqh.com and make any demographic updates to your Council for Affordable Quality Healthcare (CAQH) profile so it matches the information you are submitting to MVP and re-attest your CAQH.

Annual Notice

Following is an annual notice from the New York State Department of Financial Services (DFS). The DFS recommends that providers print and post this notice in their office. A poster version of this notice (PDF) is available for download in English and Spanish. Visit www.mvphealthcare.com and select *Privacy & Compliance* at the bottom of the homepage.

Confidentiality Protocols for Domestic Violence Victims and Endangered Victims

From the New York State Department of Financial Services Insurance Law Section 2612 and Insurance Regulation 168, effective January 1, 2013.

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.

Summary: 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 telephone 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 MVP's Customer Care Center at the address or telephone number indicated on the contact information at the end of this notice.

The requestor must provide MVP's Customer Care Center with an alternative address, phone number, or other method of contact and may be required to provide MVP's 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.

**New York State Domestic Violence
and Sexual Violence Hotline**
1-800-942-6906

MVP's Customer Care Center
MVP Customer Care Center
625 State Street
Schenectady, NY 12301
1-888-687-6277 (TTY 1-800-662-1220)

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the June 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 *Benefit Interpretation Manual* (BIM) located on **www.mvphealthcare.com**. To access the BIM, log in to your account and select *Online Resources*, then *BIM* under *Policies*. 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 Professional Relations representative.

Medical Policy Updates Effective October 1, 2016

Burn Garments and Lymphedema Sleeves: There are no changes to the medical policy criteria.

Dental Care Services Prophylactic Dental Extractions: There are no changes to the medical policy criteria.

Hyaluronic Acid Derivatives: Previously the medical policy listed a Medicare variation. The Medicare variation has been removed. The Medicare Local Coverage Determination (LCD) has been archived. Coverage for Medicare products will now follow the MVP Hyaluronic Acid Derivatives medical policy criteria.

Oxygen and Oxygen Equipment: There are no changes to the medical policy criteria.

Prophylactic Mastectomy and Oophorectomy: There are no changes to the medical policy criteria.

Robotic and Computer Assisted Surgery: There are no changes to the medical policy criteria.

Tear Osmolarity Testing for Dry Eye Disease Point of Care: The medical policy is updated to state the tear osmolality system in the office setting is considered medically necessary when used to determine the severity of clinically significant dry eye disease. Tear osmolarity must be performed by an ophthalmologist. Previously, tear osmolarity testing in the office setting was considered not medically necessary and therefore not covered.

Ventricular Reduction Surgery: There are no changes to the medical policy criteria.

Medical Policy Updates Effective January 1, 2017

Habilitation Services for Individual and Small Group Products *NEW*: Habilitation Services is a

new policy only for individual and small group products, effective January 1, 2017. The policy outlines criteria for both inpatient and outpatient settings. Criteria for inpatient habilitation services follow the same criteria that are used for acute inpatient rehabilitation admission in regards to requirements and number of days. The second set of criteria are for services in a Skilled Nursing Facility and must also meet Skilled Nursing Facility admission criteria. Outpatient section must meet requirements documented in both medical records requirement section and habilitation services section of the medical policy.

Medical Policies for approval without changes in July 2016:

- Artificial Intervertebral Discs, Cervical and Lumbar
- Autism Spectrum Disorders NH
- Breast Reduction Surgery (Reduction Mammoplasty)
- Endoscopy (Colonoscopy)
- Endovascular Repair of Aortic Aneurysm
- Endovenous Ablation of Varicose Veins
- Laser Treatment of Port Wine Stains
- Low Vision Aids
- Oxygen Therapy for Treatment of Cluster Headaches
- Personal Care and Consumer Directed Services
- Umbilical Cord Blood Banking

In-Office Procedure List Update

The MVP In-Office Procedure List has been reviewed, updated, and is effective January 1, 2017. The In-Office Procedure List is comprised of procedures that are limited to the physician's office place of service (POS). Any planned procedures on this list performed outside of the physician office at POS 22 or 24 will be denied unless prior authorized. All lines of business require prior authorization for site of service.

Participating providers are required to comply with MVP's protocols according to their participating provider agreements and a review of procedures on this In-Office Procedure List and enforcement of this POS policy is part of MVP's protocols. Since this is a POS review, there are no appeal rights. Please refer to the Place of Service Payment Policy, Split Billing Payment Policy in Section 15, Payment Policies, of the Provider Resource Manual for details on billing correct place of service. To access the In-Office Procedure List and the Provider Resource Manual, visit **www.mvphealthcare.com**,

select *Providers* and then *Log In* using your MVP username and password. Select the gray box to access your profile and choose *Online Resources* on the left hand side of the page.

Case and Condition Health Management Programs Accepting Referrals

MVP offers dedicated Population Health Management programs to members at a variety of service levels. Drawing on the combined strength of our wellness strategists, registered nurses, social workers, respiratory therapists, physicians, pharmacists, and community health care providers, MVP offers a highly focused, integrated approach to management that promotes quality, cost-effective health care throughout the care continuum. MVP Case Managers utilize key principles within the framework of nursing case management established by the American Nursing Association and the Case Management Society of America.

MVP's Condition Health Management program focuses on members with:

- Asthma
- Low back pain
- Cardiac condition (post-event based)
- COPD
- Diabetes
- Heart failure

MVP's Acute Case Management Focuses on High-Risk Target Populations

Factors considered for identifying eligible members for case management include: diagnosis, cost, utilization (emergency room and inpatient admissions) and qualitative variables (social risk, support network), as well as members' willingness to participate in case management.

Case management activities also include care of members who undergo organ transplant, have cancer, end stage renal disease, HIV/AIDS, or experience a high-risk pregnancy. Additional factors for consideration when determining member eligibility include members who are non-adherent to the plan of care and/or members who require additional guidance in navigating the health care continuum. Members who experience a critical event or diagnosis can be referred for case management services through multiple avenues.

To make a referral to our Population Health Management program, call **1-866-942-7966**, fax **1-866-942-7785**, or email **phmreferrals@mvphealthcare.com**.

CARING FOR THE ELDERLY

Improving Bone Health

Bone health and fall risk are important topics to discuss with your older adult patients. Talk to your patients about proper screenings and small lifestyle changes to develop a plan that meets their individual needs. MVP offers many resources to help assess and improve a patient's bone health.

The Fracture Risk Assessment (FRAX) tool is a useful resource to evaluate a patient's fracture risk. The calculations provided are based on patient models that incorporate risk factors and bone mineral density measurements. To access the FRAX tool, visit www.shef.ac.uk/FRAX.

Physical activity is important to improve strength and balance. The MVP Medicare Community Health Promotion team offers physical activity programs throughout the communities we serve. To view upcoming class schedules, visit www.mvphealthcare.com and select *Members*, then *Live Healthy*, and then *Health Promotion Activities*.

The SilverSneakers® Fitness program is also part of most MVP Medicare Advantage plans. Designed exclusively for Medicare-eligible adults, SilverSneakers offers a gym membership and exercise classes at thousands of locations across the country. For more information, visit www.silversneakers.com. Talk with your patients about the level of activity that's right for them.

PHARMACY UPDATES

Pharmacy Policy Updates Effective October 1, 2016

Arthritis, Inflammatory Biologic Drug Therapy

- Cosentyx added to policy

Cialis for BPH

- Enablex, Vesicare, and Toviaz added to list of examples of anticholinergics drugs

Epinephrine Auto-injector

- Auvi-Q removed from policy

Gout Treatment

- Mitigare added to policy

- Liver function test values and failure of probenecid removed from criteria

Juxtapid/Kynamro

- Policy archived

Methotrexate Auto-injector

- Otrexup 7.5mg and 17.5mg added to policy

Migraine Agents

- Added prior authorization and quantity limits to dihydroergotamine ampules
- Added prior authorization to Migranal Nasal spray (brand and generic)

Pain Medications

- Belbuca added to policy with a quantity limit of 60 films per 30 days
- Hysingla ER added to policy with a step edit and quantity limit of 30 tablets per 30 days
- Zohydro ER changed from prior authorization to step edit

Pulmonary Hypertension (Advanced Agents)

- Veletri added to policy

Orphan Drug(s) and Biologicals

- Cholbam, Juxtapid, Kynamro, Strensiq and Syprine added to policy

Formulary Updates for Commercial, Medicaid, and Marketplace Formularies

New Drugs (recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid)

Drug Name	Indication
Cabometyx tablets	Advanced cell renal carcinoma
Nuplazid tablets	Hallucinations and delusions associated with Parkinson's
Briviact tablets	Partial-onset seizures
Tecentriq injection	Urothelial carcinoma
Orfadin capsules	Hereditary tyrosinemia type 1
Ocaliva tablets	Primary biliary cholangitis
Onzetra powder	Migraines
Xtampza ER capsules	Pain
Cetylev tablets	Acetaminophen overdose
Probuphine implant	Opioid dependence

**Drugs Added to Formulary (Tier 1 for Commercial/
Medicaid and Tier 2 for Marketplace)**

rosuvastatin	flurandrenolide
armodafinil	miglitol
dofetilide	alogliptan-PA required
doxycycline DR 200mg-PA required	
alogliptan/metformin-PA required	
Alogliptan/pioglitazone-PA required	

Drugs Removed from Prior Authorization

Praxbind injection	Genvoya tablets
Belbuca films	Onivyde injection
Imlygic injection	Cotellic tablets
Yondelis injection	Gleostine capsules
Tagrisso tablets	Veltassa powder
Ninlaro capsules	Empliciti injection
Tresiba injection	



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to enroll in MVP e-communications.



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MVP Provider Directory

You can search the current MVP Provider Network at **www.mvphealthcare.com**. Select *Find a Doctor* to search for current primary care providers and specialists online.



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.

Contacting MVP Professional Relations

MVP Corporate Headquarters	1-888-363-9485
Southern Tier	1-800-688-0379
Central New York	1-800-888-9635
Midstate	1-800-568-3668
Mid-Hudson	1-800-666-1762
Buffalo and Rochester	1-800-684-9286
Vermont	1-800-380-3530

Denise V. Gonick
President & CEO

We welcome your comments.

Healthy Practices
MVP Health Care, Inc.
Professional Relations Dept.
PO Box 2207
Schenectady, NY 12301



www.mvphealthcare.com

PROFESSIONAL RELATIONS UPDATE

Launch of the MVP Health Care Electronic Claim Adjustment Request Form

MVP is excited to announce the implementation of an additional, web-based self-service claim adjustment capability for providers and their office staff.

The new portal capability offers more timely adjustment processing by allowing providers/staff to:

- electronically submit claim adjustment requests that formerly were submitted on paper for corrected CMS 1500 and UB-04 claim forms
- electronically attach supporting documentation such as office notes, invoices, or EOBs
- check the status of any claim adjustment requests that have been submitted through the MVP provider portal
- view letters in response to submitted/processed claim adjustment requests via the MVP provider portal

For an informational presentation on accessing the electronic claim adjustment request form, visit **www.mvphealthcare.com** and select *Providers*, then *Summary of CARF Enhancement*.

New Member ID Cards for MVP Harmonious Health Care Plan

As previously communicated, effective July 1, 2016, MVP Health Care began offering the MVP Harmonious Health Care Plan, a Medicaid Managed Care Health and Recovery Plan (HARP). This plan is available to existing Medicaid members age 21 and over who are identified by New York State with serious mental illness and/or substance use disorders.

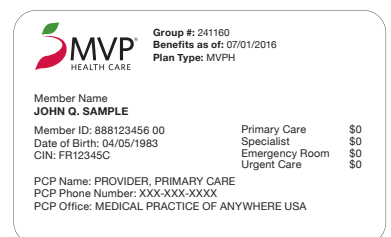
All eligible MVP Harmonious Health Care Plan members received new ID cards with Plan Type **MVPH**. Please note that reimbursement for covered medical services will be at your MVP Medicaid Managed Care contracted rate.

For more information about HARP, visit **www.mvphealthcare.com** and select *Providers*, then *Reference*, and then *MVP Harmonious Health Care Plan FAQs*.

If you have any additional questions, please contact your Professional Relations Representative or Provider Services at **1-800-247-6550**.

Online Provider Demographic Information Review Request

The Centers for Medicare and Medicaid Services (CMS) regulation 42 CFR 422.111(b)(3) and (h)(2)(ii), 422.112, 423.128(d)(2) requires that all health plans work with their provider network on a quarterly basis to confirm the



Sample MVP Harmonious Health Care Plan Member ID Card

provider demographic information in the online directory is accurate. Providers are required to review their demographic information in the MVP directory and notify MVP of any inaccuracies in the directory to be updated.

MVP is asking all participating providers to follow these steps:

- Step 1:** Visit www.mvphealthcare.com and select *Find a Doctor*, then *Search by Provider*.
- Step 2:** Search for the provider(s) in your practice and review the following demographic information for accuracy:
- Ability to accept new patients
 - Street address or missing addresses
 - Phone number
 - Other changes that affect availability to patients. (e.g. handicap accessible, specialty changes)
- Step 3:** If demographic information is identified as incorrect, please submit the correct information to MVP using the *MVP Providers Change of Information* form. To download this form, visit www.mvphealthcare.com and select *Providers*, then *Forms*. Delegated providers should contact their delegate administrator to update demographic information.
- Step 4:** If the update applies to multiple providers in the group, please include a roster of all providers to whom the change applies, including the providers name and NPI, when you submit updates to MVP.
- Step 5:** Fax or email the completed *Providers Change of Information* form to the appropriate regional fax or email address listed on the form.
- Step 6:** *Login* at www.caqh.com and make any demographic updates to your Council for Affordable Quality Healthcare (CAQH) profile so it matches the information you are submitting to MVP and re-attest your CAQH.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the May and June meetings. 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 *Benefit Interpretation Manual* (BIM) located at www.mvphealthcare.com. To access the BIM, *Log In* to your account, select *Online Resources*, and then *BIM* under *Policies*. 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 Professional Relations Representative.

Medical Policy Updates Effective June 1, 2016

- Skin Endpoint Titration:** CPT codes 95017 and 95081 do not require prior authorization effective June 1, 2016.
- Neuropsychological Testing:** CPT codes 96118 and 96119 do not require prior authorization effective June 1, 2016.

Medical Policy Updates Effective August 1, 2016

- Amniotic Membrane Transplant:** There are no criteria changes to the medical policy.
- Breast Pumps:** Breast pump supplies are now covered for MVP Medicaid products. Previously, breast pump supplies were not covered for MVP Medicaid products.
- Cryoablation of Breast Fibroadenomas:** **ARCHIVED**
The Cryoablation of Breast Fibroadenomas medical policy is archived.
- Dental Care Services Accidental Injury:** There are no criteria changes to the medical policy.
- Experimental and Investigational Procedures:** The medical policy was updated to include language for coverage Phase 4 clinical trials.
- External Breast Prosthesis:** There are no criteria changes to the medical policy.
- Gas Permeable Scleral Contact Lenses:** **NEW POLICY**
This is a new medical policy. The policy addresses coverage criteria for BostonSight® PROSE, which is an ocular surface ecosystem prosthesis. It is intended for use in individuals with ocular surface disease and corneal issues. The BostonSight® PROSE device can only be ordered by an ophthalmologist.
- Heart Transplant Rejection Testing:** There are no criteria changes to the medical policy.
- High Frequency Chest Wall Oscillation Devices:**
There are no criteria changes to the medical policy.
- Hip Surgery for Femoroacetabular Impingement, Acetabular Labral Tears, and Snapping Hip Syndrome:** There are no criteria changes to the medical policy.
- Home Prothrombin Time Monitoring:** **ARCHIVED**
The Home Prothrombin Time Monitoring medical policy is archived.
- Immunizations Childhood/Adolescent/Adult:**
There are no criteria changes to the medical policy.

Magnetoencephalography: There are no criteria changes to the medical policy.

Mechanical Stretching Devices: There are no criteria changes to the medical policy.

Monitored Anesthesia Care: There are no criteria changes to the medical policy.

Needle-free Insulin Injectors: There are no criteria changes to the medical policy.

Obstructive Sleep Apnea: Diagnosis: CPT codes 95810 and 95811 do not require prior authorization effective August 1, 2016. There are no criteria changes to the medical policy.

Panniculectomy/Abdominoplasty: There are no criteria changes to the medical policy.

Phototherapy, Photochemotherapy, and Excimer Laser Therapy: There are no criteria changes to the medical policy.

Prosthetic Devices Upper and Lower Limb: The medical policy was updated with the following Medicare National Coverage Determination (NCD) Prosthetic Devices language changes:

- Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of foot or foot addition (such as L5968 Multiaxial ankle with dorsiflex).
- Foot covers are included in the codes for a prosthetic foot component and are not separately covered upon initial issue of a new prosthetic.
- Socket replacements are considered medically necessary if there is adequate documentation of functional and/or physiological need. It is recognized that there are situations where the explanation includes, but is not limited to, changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive patient weight or prosthetic demands of very active amputees.
- Codes L5940–L5960 for ultra-light materials may only be used when materials such as carbon fiber, fiberglass, Kevlar®, or other advanced composite lamination materials are used in the fabrication of a socket for an endoskeletal prosthesis. They are not used for ultralight materials used in other components of a prosthesis, e.g., knee/shin system, pylon, ankle, foot, etc. For codes L5940–L5960, the unit of service is per limb.
- Vacuum pump systems (codes L5781, L5782) are covered when:
 - the patient has a documented clinical condition of volume variation with objective measurements of the residual limb provided

over a period of time (excluding any volume change due to weight gain, weight loss, the normal atrophy process, growth, or systemic issues such as vascular or cardiac issues which would cause volume changes despite the use of vacuum technology);

- documented clinical condition of moisture retention with evidence of dermatological issues caused by the excessive perspiration;
 - a history of slow or non-healing wounds;
 - or reduced proprioceptive capabilities.
- Protective outer surface covering systems (codes L5962, L5964, and L5966) are specialized covers intended to be worn over an existing prosthesis. They are used by a beneficiary who has special needs for protection against unusually harsh environmental situations where it is necessary to protect the lower limb prosthesis beyond the level of that which is afforded by codes L5704–L5707. They are not covered for cosmetic or convenience reasons, or for everyday usage in a typical environment. Documentation to support medical necessity of a protective outer surface covering system (L5962, L5964, and L5966) must indicate the type of extraordinary activities that would justify the need for extra protection afforded by this highly durable item.
 - Partial Foot Code L5000—(partial foot, shoe insert with longitudinal arch toe filler) is covered when member has partial foot or toe amputations.

Skin Endpoint Titration: CPT codes 95017 and 95081 do not require prior authorization effective 6/1/16. There are no criteria changes to the medical policy.

Transplants: There are no criteria changes to the medical policy.

Scoliosis Bracing: There are no criteria changes to the medical policy.

Vitiligo Treatment: MVP continues with its longstanding position that vitiligo is cosmetic and treatments for vitiligo are not medically necessary.

Medical Policies for Approval Without Changes in May and June 2016:

Bariatric surgery

Benign Skin Lesions

Electromyography & Nerve Conduction Studies

Evaluation of New Technology

FISH Testing for Bladder Cancer Screening

Imaging Procedures

Implantable Cardioverter Defibrillators

Medical Policy Development, Impl, Review Process

Negative Pressure Wound Therapy Pumps
Photodynamic Therapy for Malignant and Non-Malignant Indications
Temporomandibular Joint Dysfunction (TMJ) NY/NH
Temporomandibular Joint Dysfunction (TMJ) VT
Transcatheter Aortic Valve Replacement
Vision Therapy (Orthoptics, Eye Exercises)

PROVIDER RESOURCE MANUAL UPDATES

Modifier 50

MVP recently identified a system configuration error that allowed reimbursement for procedures billed with a Modifier 50 and a quantity of two. Retro adjustments are being performed on overpayments as they are identified per MVP Modifier Payment Policy.

Description

Used to report bilateral procedures (CPT codes 10040–69990) performed in the same operative session and radiology procedures performed bilaterally. Bilateral procedures that are performed at the same session should be identified by adding Modifier 50 to the appropriate five digit code.

Rule

- Identify that a second (bilateral) procedure has been performed by adding Modifier 50 to the procedure code.
- Do not report two line items to indicate a bilateral procedure.
- Do not use modifier with surgical procedures identified by their terminology as “bilateral” (e.g., 27395, lengthening of hamstring tendon, multiple, bilateral), or as “unilateral or bilateral” (e.g., 52290, cystourethroscopy, with meatotomy, unilateral or bilateral).
- Report only one unit of service when Modifier 50 is reported.
- Modifier 50 should not be appended to a claim when appending the LT/RT modifiers.

Reimbursement

150 percent of the providers contracted rate.

Effective September 1, 2016, MVP will implement an upfront system edit to automatically deny any claim billed with Modifier 50 and quantity of two as a billing error. Modifier 50 denotes a bilateral procedure which represents this procedure has occurred twice. Billing this modifier with a quantity of two is considered incorrect billing.

For more information on MVP's payment policies, found in the *MVP Provider Resource Manual*, visit www.mvphealthcare.com and select *Providers*, then *Log In* to your provider portal account, then select *Provider Snapshot* in the gray box, then *Online Resources*, and then *Online Resources*. All Payment Policies are found in Section 15.

PHARMACY UPDATES

Metformin ER

Fortamet, Glumetza, and their generic equivalents require prior authorization for Commercial, Exchange, and Medicaid members.

Glucophage

Glucophage XR and their generic equivalents are covered without prior authorization and must be used prior to Fortamet and Glumetza. Please see the Metformin ER policy for full criteria.

Policy Updates Effective June 1, 2016

Hepatitis C Treatment

- Updated drugs to include Daklinza and Zepatier. Harvoni is preferred for all plans and Zepatier is co-preferred for Medicaid.
- Eliminated Hepatitis C disease severity criteria, such as fibrosis or certain co-morbidities
- Updated treatment criteria and durations of approval to reflect current AASLD/IDSA guidelines

Policy Updates Effective July 1, 2016

Diclofenac (topical) Products

- Add generic Voltaren gel (diclofenac 1% gel) to policy
- Changed criteria for Voltaren gel to failure of two oral NSAIDs

Metformin ER

- Fortamet and the generic equivalent will require prior authorization
- Criteria for Glumetza and the generic equivalent was updated

Policy Updates Effective August 1, 2016

Inhaled Corticosteroids and Combination

- Prior authorization removed for Advair

Xolair

- Chronic idiopathic urticaria criteria updated

Cystic Fibrosis (Select Agents for Inhalation)

- Medicare variation updated to included non-cystic fibrosis bronchiectasis for Tobi

Cystic Fibrosis (Select Oral agents)

- CFQ-R removed for extension criteria and replaced with decrease in number of pulmonary exacerbations for baseline

Idiopathic Pulmonary Fibrosis

- No changes

Cough and Cold Products (Brands)

- No changes

Preventive Services-Medications

- Iron supplementation for children age 6-12 months will no longer be covered as of October 1, 2016

Formulary Updates for Commercial, Medicaid, and Marketplace Formularies

New Drugs (recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid)

Drug Name	Indication
Vraylar	Bipolar I and schizophrenia
Vistogard	Fluoruracil or capecitabine overdose
Odefsey	HIV
Idelvion	Hemophilia B
Otiprio	Used with tympanostomy tube placement
Spritam	Partial onset and Myoclonic seizures
Allzital	Tension headache
Alprolix	Hemophilia B
Taltz	Plaque psoriasis
Defitelio	VOD
Cinqair	Severe asthma
Venclexta	CLL
Impavido	Leishmaniasis
Evomela	Multiple Myeloma
Wilate	Hemophillia A
Adzenys XR	ADHD
Zembrace	Migraine
Descovy	HIV

Drugs Added to Formulary (Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace)

Darifenacin ER	Doxepin cream
Frovatriptan	Mometasone nasal
Zolpidem SL	

Drugs Removed from Prior Authorization

Zarxio	Synjardy	Envarsus XR
Tolak	Odomzo	Lonsurf
Aristada	Varubi	



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MVP Provider Directory

You can search the current MVP Provider Network at **www.mvphealthcare.com**. Select *Find a Doctor* to search for current primary care providers and specialists online.

Get **HEALTHY PRACTICES** by email! Complete the form at **www.mvphealthcare.com/providerpreferences** to enroll in MVP e-communications.

Contacting MVP Professional Relations

MVP Corporate Headquarters	1-888-363-9485
Southern Tier	1-800-688-0379
Central New York	1-800-888-9635
Midstate	1-800-568-3668
Mid-Hudson	1-800-666-1762
Buffalo and Rochester	1-800-684-9286
Vermont	1-800-380-3530

Denise V. Gonick
President & CEO

We welcome your comments.

Healthy Practices
MVP Health Care, Inc.
Professional Relations Dept.
PO Box 2207
Schenectady, NY 12301



www.mvphealthcare.com

PROFESSIONAL RELATIONS UPDATE

Provider Demographic Review

The Centers for Medicare and Medicaid Services (CMS) regulation 42 CFR 422.111(b)(3) and (h)(2)(ii), 422.112, 423.128(d)(2) requires that all health plans work with their provider network on a quarterly basis to confirm the provider demographic information in the online directory is accurate. Providers are required to review their demographic information in the MVP directory and notify MVP of any inaccuracies in the directory to be updated.

MVP is asking all participating providers to follow these steps:

Step 1: Visit **www.mvphealthcare.com** and select *Find a Doctor*, then *Search by Provider*.

Step 2: Search for the provider(s) in your practice and review the following demographic information for accuracy:

- Ability to accept new patients
- Street address or missing addresses
- Phone number
- Other changes that affect availability to patients. (e.g. handicap accessible, specialty changes)

Step 3: If demographic information is identified as incorrect, please submit the correct information to MVP using the *MVP Providers Change of Information* form. To download this form, visit **www.mvphealthcare.com** and select *Providers*, then *Forms*. Delegated providers should contact their delegate administrator to update demographic information and they will follow their normal monthly process of communicating updates to MVP.

Step 4: If the update applies to multiple providers in the group, please include a roster of all providers to whom the change applies, including the providers name and NPI, when you submit updates to MVP.

Step 5: Fax or email the completed *Providers Change of Information* form to the appropriate regional fax or email address listed on the form.

Step 6: *Login* at **www.caqh.com** and make any demographic updates to your Council for Affordable Quality Healthcare (CAQH) profile so it matches the information you are submitting to MVP and re-attest your CAQH.

A request to review demographic information will be sent to providers quarterly.

PROVIDER QUALITY IMPROVEMENT MANUAL UPDATES

Clinical Guidelines Re-endorsed

The MVP Quality Improvement Committee (QIC) recently re-approved the following enterprise-wide clinical guidelines:

Prevention and Treatment of Osteoporosis

MVP continues to endorse the recommendations of the National Osteoporosis Foundation (NOF) Prevention and Treatment of Osteoporosis guideline. The NOF reviewed and updated the guideline in 2014. The guideline contains a summary section which highlights the following: Universal Recommendations, Diagnostic Assessment, Vertebral Imaging, Pharmacologic Treatment Recommendations, and Monitoring Patients. The full NOF Clinician's Guide can be found at my.nof.org and selecting *Resources for Professionals*.

Practice Guidelines for the Management of End Stage Renal Disease (ESRD)

MVP adopted guidelines for End Stage Renal Disease (ESRD) based on the National Kidney Foundation's Kidney Disease Outcome Quality Initiative (NKF KDOQI™). The National Kidney Foundation has published numerous Clinical Practice Guidelines through its KDOQI process. Topics covered include Chronic Kidney Disease (CKD, Dialysis Care, and Cardiovascular Disease in Dialysis Patients). There are no recent updates to these guidelines. For all KDOQI Guidelines for Chronic Kidney Disease (CKD) Care and KDOQI Guidelines for Dialysis Care, visit www.kidney.org and select *Professionals*, then *KDOQI*.

Adult Preventive Care Guidelines

As part of its continuing Quality Improvement Program, MVP has adopted Adult Preventive Care Guidelines. The adult guidelines reflect recommendations by the U.S. Preventive Services Task Force. To view the recommendations, visit www.uspreventiveservicestaskforce.org and select *Recommendations*. Tools for Primary Care Providers can be found by visiting www.uspreventiveservicestaskforce.org and selecting *Information for Health Professionals*.

For adult immunizations, MVP endorses the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) recommendations. A copy of their Immunization Schedule is available by visiting www.cdc.gov and selecting *Vaccines & Immunizations* under *Healthy Living*, then *Immunization Schedules*, then *For Health Care Professionals*, and then *Adult Immunization*.

Asthma

As part of our continuing Quality Improvement Program, MVP endorses recommendations for Asthma care that are a result of a collaborative effort led by the New York State Department of Health (NYSDOH). Collaborators include NYSDOH, the New York City Department of Health and Mental Hygiene, MVP Health Care, and other health plans

and professional organizations from across New York State. The guideline is derived from the Third Expert Panel Report 3 (EPR3). The EPR3 Asthma guideline was developed by an expert panel commissioned by the National Asthma Education and Prevention Program (NAEPP) Coordinating Committee (CC), National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health (NIH). The NYSDOH *Clinical Guideline for the Diagnosis, Evaluation, and Management of Adults and Children with Asthma* can be found by visiting www.health.ny.gov and selecting *Providers/Professionals*, then *Diseases & Conditions*, and then *Asthma*.

In New York, MVP encourages practitioners to use the NYSDOH's *Asthma Action Plan* with their patients and families. The form is available by visiting www.health.ny.gov and selecting *Publications and Educational Material* at the bottom of the page, then *Asthma*, and then *Form 4850*.

Practitioners in Vermont are encouraged to use a similar form produced by the Vermont Department of Health. For copies of the Vermont Asthma Action Plan form, contact the Vermont Department of Health Asthma Program at **1-866-331-5622**. A sample of the Vermont action plan and can be found by visiting www.healthvermont.gov and selecting *Diseases and Prevention*, then *Asthma*, and then *Tools for Managing Asthma*.

In conjunction with these guidelines, MVP Health Care offers a Condition Health Management program for our members with a diagnosis of Asthma. If you would like to refer one of your patients to this program, please call MVP Population Health Case Management at **1-866-942-7966**. More information on this and MVP's other health programs may also be found at www.mvphealthcare.com by selecting *Providers* and then *Programs for members with chronic health concerns* under *Condition Health Management*.

Attention Deficit Hyperactivity Disorder (ADHD)

As part of our continuing Quality Improvement Program, MVP has adopted the American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (2011 update). This guideline can be found in the Behavioral Health section of the *Provider Quality Improvement Manual* by visiting www.mvphealthcare.com and selecting *Providers*.

The National Initiative for Children's Healthcare Quality (NICHQ) has developed a toolkit specifically for ADHD. Items in the toolkit include ADHD evaluation forms and written treatment plans for the primary care clinician; the Vanderbilt Assessment

scales and scoring information for parents, educators, and clinicians; educational materials for parents and additional resources. The toolkit is available by visiting www.nichq.org and selecting *Children's Health*, then *ADHD*, then *Resources*, and finally *ADHD Toolkit*.

In addition, for our New York practitioners, Beacon Health Options offers a toll-free Provider Consult Line staffed by Board Certified Psychiatrists. These psychiatrists are available for telephonic consultation regarding all aspects of mental health and substance abuse treatment for children and adults, including appropriate use of psychotropic medications. The consult line is a valuable tool in educating Primary Care Providers (PCP) on how to screen for and manage children with ADHD as well as answering specific questions. PCP's as well as Specialists may contact the Beacon Health Options Provider Consult Line for consultation at **1-877-241-5575**, Monday-Friday, 8am-5pm Eastern Time.

Chronic Obstructive Pulmonary Disease (COPD)

As part of MVP's continuing Quality Improvement Program, we have adopted the Global Initiative for Chronic Obstructive Lung Disease's (GOLD) clinical guideline for the diagnosis, management, and prevention of COPD (2011 update).

The GOLD Guideline for COPD, *Global Strategy for the Diagnosis, Management, and Prevention of COPD* can be found by visiting www.goldcopd.com and selecting *Documents & Resources*. Also available on the *Documents & Resources* page are the *Pocket Guide to COPD Diagnosis, Management, and Prevention* and the *GOLD Spirometry Guide*.

Oncology

As part of MVP's continuing Quality Improvement Program, we have adopted the National Comprehensive Cancer Network's (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for the treatment and management of cancer. The National Comprehensive Cancer Network is a not-for-profit alliance of 21 of the world's leading cancer centers working together to improve the quality, effectiveness, and efficiency of cancer care.

Providers may access the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) by visiting www.nccn.org by selecting *NCCN Guidelines®*. Numerous guidelines for the treatment and management of cancer are available by selecting *NCCN Guidelines for Treatment of Cancer by Site*. Also available on this page are links to several pocket guidelines available free of charge. You will need to complete the brief, free registration to *Login* and download the documents.

In conjunction with these guidelines, MVP Health Care offers Case Management for members in active treatment for cancer. If you would like to refer one of your patients to this program, please call MVP Population Health Case Management at **1-866-942-7966**.

Perinatal Care

MVP Health Care has adopted perinatal care practice guidelines as part of its continuing Quality Improvement Program. These practice guidelines primarily reflect the recommendations put forth in the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (AAP/ACOG) Guidelines for Perinatal Care, Seventh Edition. October, 2012.

The AAP/ACOG guidelines are available by visiting www.acog.org and selecting *Resources & Publications*. Guidelines are free to ACOG members. Non-members and members of the public can purchase the printed guidelines from the ACOG online store.

In addition to the AAP/ACOG guidelines, all clinicians who provide prenatal care for MVP Medicaid Managed Care patients should be aware of, and follow, the New York State Medicaid guidelines. To access the New York State Medicaid prenatal care guidelines, visit www.health.ny.gov and select *Providers/Professionals*, then *Health Topics A to Z*, then *Managed Care*, and then *Medicaid Prenatal Care Standards*.

In conjunction with these guidelines, the MVP Little FootprintsSM program offers high-risk prenatal care. The Little Footprints program includes phone calls from a registered nurse specializing in high-risk maternity for one-on-one education, case management support, and intervention during a high-risk pregnancy. All Medicaid members are eligible for the Little Footprints program. Those members who are not eligible for the Little Footprints program are referred to the Healthy Starts program for an educational packet via mail. The Healthy Starts program gives mothers-to-be information that helps them stay healthy, learn about pregnancy, and prepare for delivery. If you would like to refer one of your patients to either of these programs, please call MVP Population Health Case Management at **1-866-942-7966**.

Secondary Prevention of a Cardiac Event in Patients with Atherosclerotic Cardiovascular Disease

As part of our continuing Quality Improvement Program, MVP has adopted the American Heart Association (AHA) and the American College of Cardiology Foundation (ACCF) Guidelines, Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic

Vascular Disease (2011 Update). These guidelines are endorsed by the National Heart Lung Blood Institute (NHLBI) of the National Institutes of Health (NIH).

The guideline is available at www.heart.org by selecting *Healthcare/Research* and then *Guidelines/Statements*. The American Heart Association is a national voluntary health agency to help reduce disability and death from cardiovascular diseases and stroke.

The MVP guideline cover page note in the Key Guideline Messages for blood pressure control is from 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults. Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC8). AHA/ACCF (2011 update) has not updated the guidelines with the blood pressure recommendations from JNC8. Lipid management is from the 2013 American College of Cardiology (ACC)/American Heart Association (AHA) Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. AHA/ACCF (2011 update) has not updated the guidelines with the lipid management recommendations from 2013 ACC/AHA guideline.

In conjunction with these guidelines, MVP Health Care offers a Condition Case Management program for members who have recently experienced a cardiac event (myocardial infarction, angioplasty, and/or stent placement). If you would like to refer one of your patients to this program, please call MVP Population Health Case Management at **1-866-942-7966**.

More information on MVP's health programs is available at www.mvphealthcare.com by selecting *Providers* and then *Programs for members with chronic health concerns*.

MVP Health Care updates its clinical guidelines at least every two years. The review process is also initiated when new scientific evidence or national standards are published. Paper copies of these recommendations are available by calling the MVP Quality Improvement Department at **1-800-777-4793 ext. 12602**. The recommendations will also be available in an update to the MVP Provider Quality Improvement Manual.

To access the current edition of the *Provider Quality Improvement Manual*, visit www.mvphealthcare.com and select *Providers*.

Change to Reimbursement for Medicaid SSI Behavioral Health Services

Effective July 1, 2016, Medicaid Managed Care (MMC) plans will cover behavioral health benefits. This change impacts reimbursement for inpatient/outpatient behavioral health services provided to

MVP's Medicaid SSI members that were previously treated as fee-for-service by Medicaid.

Behavioral health services that now fall under MMC include:

- Inpatient Rehabilitation and Treatment Services and Outpatient Services for Chemical Dependence
- Inpatient and Outpatient Mental Health Services

Behavioral health services for SSI members will be available through providers that participate with Beacon Health Options—MVP's behavioral health vendor. Claims for covered services should be submitted to Beacon for payment.

Update Regarding MVP's New HARP Plan

Effective July 1, 2016, MVP Health Care will offer the MVP Harmonious Health Care Plan, a Medicaid Managed Care Health and Recovery Program (HARP).

The MVP Harmonious Health Care Plan is available to existing Medicaid members aged 21 and over who have been identified by New York State as suffering from serious mental illnesses and/or substance use disorders.

Plan members will receive new Member ID cards from MVP. However, reimbursement for covered services will remain at the same rate that is currently provided to all Medicaid members.

While traditional Medicaid benefits will be available, MVP Harmonious Health Care Plan also provides members with access to a broad range of physical and behavioral health benefits from Home and Community-Based Services (HCBS) through MVP's behavioral health vendor, Beacon Health Options.

Network providers recently received a copy of Frequently Asked Questions about HARP and an Amendment to the MVP Health Care Participating Agreement that detailed participation in the MVP Harmonious Health Care Plan.

Additional resources and information about HARP can be found by visiting www.omh.ny.gov and selecting *Behavioral Health Providers*, then *Behavioral Health Managed Care*, then *Overview*, and then *Health and Recovery Plans (HARPs)*.

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

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 *Benefit Interpretation Manual* (BIM) located at www.mvphealthcare.com. To access the BIM, Log In to your account, select *Online Resources*, and then *BIM* under *Policies*. 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 Professional Relations Representative.

Medical Policy Updates Effective June 1, 2016

- Adult Day Care:** This policy applies to Medicaid Managed Care only. There are no changes to the indications/criteria of the medical policy.
- Artificial Heart:** There are no changes to the indications/criteria of the medical policy.
- Biofeedback:** There are no changes to the indications/criteria of the medical policy.
- Cold Therapy Devices:** There are no changes to the indications/criteria of the medical policy.
- Emergency Department Services:** There are no changes to the indications/criteria of the medical policy.
- Feeding and Eating Disorders Behavioral Health:** Previously, the medical policy was named Eating Disorders. The medical policy has been renamed Feeding and Eating Disorders Behavioral Health. The policy is formatted to list the levels of care. For each level of care there is admission, exclusion, continued stay, and discharge criteria. The criteria follow Beacon Health Options criteria.
- Gender Reassignment:** Previously, the medical policy was named Gender Reassignment Surgery. The policy was renamed Gender Reassignment to reflect that it covers both pharmaceutical and surgical gender reassignment. The medical policy follows New York State Medicaid guidelines. Two letters recommending surgery from behavioral health specialists are required and criteria for those letters are listed. For male to female transitions, breast augmentation is covered if the member meets criteria for surgical reassignment and also completes 24 months of hormone replacement therapy with no breast growth or hormone replacement therapy is contraindicated. For female to male transitions, mastectomy is covered. Revision of breast augmentation surgery without significant functional difficulty is not covered.
- Mental Health Services:** The policy is formatted to list the levels of care. For each level of care there is admission, exclusion, continued stay, and discharge

- criteria. The criteria follow Beacon Health Options criteria.
- Neuropsychological Testing:** The policy has been updated to include psychologist or psychiatrist as specialty physicians that may order neuropsychological testing.
- Oncotype DX Testing:** There are no changes to the indications/criteria of the medical policy.
- Penile Implants for Erectile Dysfunction:** Penile implants are covered when a member fails conservative treatment. The Medicaid variation states vacuum erection systems are limited to a diagnosis of impotence with the order of a urologist or neurologist. The Medicare variation states that Medicare no longer covers vacuum systems or implants.
- Phototherapeutic Keratectomy:** There are no changes to the indications/criteria of the medical policy.
- Power Mobility Devices:** Previously, the medical policy was named Electric Wheelchairs and Power Scooters. The medical policy follows Medicare criteria.
- Speech Therapy:** There are no changes to the indications/criteria of the medical policy. The Medicaid variation follows the Medicaid requirements for speech therapy: documentation requirements, benefit limits and the conditions under which the 20 visit limitation does not apply, long term and restorative therapy criteria.
- Substance Use:** This policy was formerly named Chemical Dependency. The policy is formatted to list the levels of care. For each level of care there is admission, exclusion, continued stay, and discharge criteria. The criteria follows Beacon Health Options criteria.
- Substance Use Medication Management:** This policy was formerly named Opioid Substitution Therapy. The policy is formatted to list the levels of care. For each level of care there is admission, exclusion, continued stay, and discharge criteria. The criteria follow Beacon Health Options criteria.

CARING FOR OLDER ADULT PATIENTS

Testing and Treatment of Osteoporosis

Osteoporosis is a disabling condition that affects 55 percent 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 Health Care 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 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 osteoporosis and medications to prevent it, the condition remains largely under-diagnosed and under-treated.

According to MVP's 2015 HEDIS results, only approximately 17 percent of women ages 67-85 received a BMD test or prescription for a medication to treat/prevent osteoporosis within the six-months following a fracture.

For more information, MVP's Prevention and Treatment of Osteoporosis guideline is available at www.mvphealthcare.com by selecting *Providers*, then *Provider Quality Improvement Manual*, and finally *Caring for Older Adults*.

CLINICAL QUALITY UPDATE

Breastfeeding Support

MVP recognizes the importance of breastfeeding babies and we are committed to ensuring that breastfeeding support is available for every mother and child we cover. We now offer a comprehensive lactation support program that provides guidance while breastfeeding and the necessary equipment through Corporate Lactation Services.

Through this relationship with Corporate Lactation Services, MVP offers nursing mothers breastfeeding equipment and access to board certified lactation consultants 365 days-a-year. This support program

includes outreach calls placed at specific times to provide mothers with information appropriate to the age of their child. Moms can also call in with questions or concerns until weaning.

All of these services are offered at no additional charge to our members. Benefit limitations may apply. Members may call the MVP Customer Care Center at the phone number on the back of their Member ID card to see if they qualify.

To enroll in this support program, members can visit www.corporatelactation.com and select *Subsidy Login*, then enter the company code, *MVP2229*. Members can contact Corporate Lactation Services by calling **1-888-818-5653**.

Smoking Cessation Benefits for Medicaid Enrollees

Many people who use tobacco want to quit, but need help. There are tools and support available to help you encourage your patients to quit smoking. Medicaid expanded coverage of Smoking Cessation Counseling (SCC) to all Medicaid beneficiaries on March 1, 2014 and MVP extended that benefit to all Medicaid enrollees. The expanded benefit allows each member a total of eight SCC sessions per calendar year, in addition to coverage of prescribed smoking cessation medications or over-the-counter nicotine replacement therapy products.

Prior authorization is not needed to provide or bill for SCC services. However, practices may call the MVP Provider Services Department at **1-800-684-9286** to verify that a member has not exceeded the allowed eight visits per year. Services are reimbursable when provided face-to-face by a physician, physician assistant, nurse practitioner, or midwife. SCC may take place during individual or group counseling sessions and may be billed as a stand-alone service or on the same day that a separate evaluation and management service is billed. Patient records must include information on the service provided and the duration of the counseling session. Reimbursement will be at contracted rates.

- Claims must include at least one of the following ICD-10-CM diagnosis code(s), for Nicotine Dependence, F17.200, F17.201, F17.210, F17.211, F17.220, F17.221, F17.290, or F17.291, **and**
- CPT 99406-Intermediate SCC, 3-10 minutes (billable only as an individual session), **or**
- CPT 99407-Intensive SCC, greater than 10 minutes (billable as an individual or group session; using the "HQ" modifier to indicate a group SCC session, up to eight patients in a group), **or**

- G9016–Smoking cessation counseling 6–10 minutes, **or**
- S9453–Smoking cessation counseling and smoking cessation classes.
- Providers reimbursed for SCC through Ambulatory Patient Groups must comply with billing guidelines detailed in the New York State Medicaid Update; April 2011, Volume 27, Number 5, available at www.health.ny.gov.

If your patient would like more information to help them quit using tobacco or to assess if they are ready, they can visit www.mvphealthcare.com and select *Members*, then *Live Healthy*, and finally *Health Tools & Calculators*. Physicians are urged to also advise patients that phone and online quit support is available free from the New York State Smokers' Quitline at **1-866-NY-QUITS (1-866-697-8487)** or www.nysmokefree.com.

PHARMACY UPDATES

Electronic Prescribing Mandate

Starting March 27, 2016, electronic prescribing for both controlled and non-controlled substances is mandatory in New York State.

- Non-prescription items such as durable medical equipment do not need to be electronically prescribed.
- Official New York State Prescription forms may be used in the event of a power outage or technical failure.

For additional information, visit www.health.ny.gov and select *Providers/Professionals*, then *Narcotic Enforcement*, then *Electronic Prescribing*, and finally *FAQs (PDF)*.

New Quantity Limits for Medicaid

Effective April 1, 2016, there will be a new quantity limits for Medicaid members on the following drugs:

- brand and generic Adderall XR, one capsule per day
- buprenorphine sublingual tablet, three tablets per day

Lidocaine (Topical) Products for Medicaid

Lidocaine cream, ointment, jelly, and patches require prior authorization for Medicaid members. Criteria for the cream, ointment, or jelly includes that they are being used for a FDA or compendia approved indication such as local anesthesia for short term use, partial thickness burns, neuropathic pain associated

with malignancy, urethral procedure, or urethritis. Criteria for lidocaine patches include that they are being used for the treatment of post-herpetic neuralgia or diabetic neuropathy. Requests that are submitted for non-FDA or compendia approved indication will not meet the policy criteria and therefore will not be approved.

Medicare Part D Prescriber Enrollment

The Center for Medicare & Medicaid Services (CMS) has delayed the enforcement of the Part D Prescriber Enrollment requirements until February 1, 2017. For more information please visit www.cms.gov and select *Medicare*, then *Medicare Provider-Supplier Enrollment*, and finally *Part D Prescriber Enrollment-Home*.

Policy Updates Effective June 1, 2016

Copay Adjustment for Medical Necessity:

- No changes

Cosmetic Drug Agents:

- The following drugs were added: Latisse, Chromelin, Vitadye, Melquin, Aclaro, and Kinerase
- The following discontinued drugs were removed: Artra and Obagi

Diclofenac (topical) Products **NEW POLICY**

- The following products will now require prior authorization for Medicaid members only- diclofenac 1.5% drops, diclofenac 3% gel, Flector patch, Pennsaid drops, Solaraze gel, Voltaren gel
- Criteria will include failure or contraindication to oral NSAID's Glumetza
- Generic Glumetza will also require prior authorization

Lidocaine (topical)

- Lidocaine patch criteria will now include failure of 1800mg of gabapentin for post-herpetic neuralgia and 60mg duloxetine for diabetic neuropathy

Medicare Part B vs. Part D Determination

- Policy updated to include coverage criteria for inhalation drugs, infusion pump drugs, immunosuppressive drugs, hemophilia clotting factors, oral anti-cancer drugs, oral anti-emetic drugs, immunizations, parenteral nutrition, and IVIG

Psoriasis Drug Therapy:

- Criteria for Cosentyx added to policy
- Stelara will be covered as a medical benefit
- Criteria for Humira used for the treatment of Hidradenitis Suppurativa added to policy

Formulary Updates for Commercial, Medicaid, and Marketplace Formularies

New Drugs (recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid)

Drug Name	Indication
Nucala	Severe asthma with eosinophilic phenotype
Iressa	NSCLC with EGFR exon 19 deletions or exon 21 substitutions
Darzalex	Multiple Myeloma after 3 prior lines of therapy
Kanuma	Lysosomal Acid Lipase deficiency
Portrazza	First line treatment of NSCLC
Alecensa	NSCLC after failure of crizotinib
Bendeka	CLL or NHL after progression on rituximab

Drug Name	Indication
Uptravi	Pulmonary arterial hypertension
Dyanavel XR	ADHD
Quillichew ER	ADHD
Propel Imp	Chronic sinusitis
Xuriden	Hereditary orotic aciduria
Enstilar foam	Plaque psoriasis

Drugs Added to Formulary (Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace)

Imatinib
Metoformin ER (generic Glumezta), prior authorization required
Naftifine cream 2%

Drugs Removed from Prior Authorization

Entresto Natpara
Prestalia Rezulti



UN-CASHED CHECKS?
Visit www.longlostmoney.com to see if MVP has any un-cashed checks in your name or in the name of your business.

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Contacting MVP Professional Relations

MVP Corporate Headquarters	1-888-363-9485
Southern Tier	1-800-688-0379
Central New York	1-800-888-9635
Midstate	1-800-568-3668
Mid-Hudson	1-800-666-1762
Buffalo and Rochester	1-800-999-3920
Vermont	1-800-380-3530

Denise V. Gonick
President & CEO

We welcome your comments.
Healthy Practices
MVP Health Care, Inc.
Professional Relations Dept.
PO Box 2207
Schenectady, NY 12301



www.mvphealthcare.com

PROFESSIONAL RELATIONS UPDATE

Provider Forms

MVP has created several forms for registering providers who do not require credentialing and for updating demographic information. These forms have recently been updated in the past few months with information that MVP is required to collect in order to update a provider's demographic information or register the provider in MVP's system. In addition to the new fields, we have added new ways of contacting MVP with your update requests, including a new centralized email address for each region. The centralized email address can be accessed by several staff within MVP, ensuring your requests are viewed and processed as quickly as possible. We urge all providers to utilize these email addresses for their demographic updates, registrations, and new provider requests.

MVP updates the forms on the website on a regular basis, so it is imperative that providers utilize the most current form available. Beginning April 1, 2016, MVP will begin reminding providers using an old form that they must use the most current version of the form.

Effective July 1, 2016, MVP will no longer accept a registration or provider demographic update form that is not the current version of the form available online. To ensure you are using the current version of a form, please download the form each time you need to use it. We appreciate your cooperation with this matter so we can serve you better.

Annual Utilization Management Satisfaction Survey Mailing

MVP is mailing our annual Utilization Management Satisfaction Survey to providers. The survey is mailed at the end of February to providers with a specialty type that work closely with the utilization management team. If you have not received the survey yet, please be looking 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, or address, phone number, or tax ID number changes.

To report demographic changes to MVP, please complete a Provider Demographic Change form. The form can be downloaded by visiting **www.mvphealthcare.com** and selecting *Providers*, then *Forms*, and then the appropriate form under *Provider Demographic Change Forms*.

Please return the completed demographic change form on letterhead to the appropriate fax number or email below.

East New York and Massachusetts

518-836-3278

eastpr@mvphealthcare.com

Central, Mid-State, or Southern Tier New York

315-736-7002

centralprdept@mvphealthcare.com

Rochester

1-800-684-9286

RocProviderChanges@mvphealthcare.com

Mid-Hudson New York

914-372-2035

MidHudsonprdept@mvphealthcare.com

Vermont

802-264-6555

vpr@mvphealthcare.com

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

PROVIDER QUALITY IMPROVEMENT MANUAL UPDATES

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Clinical Guidelines Re-Endorsed

The MVP Quality Improvement Committee (QIC) recently re-approved the following enterprise-wide clinical guidelines:

Heart Failure in Adults Guideline

MVP continues to endorse the Institute for Clinical Systems Improvement's Heart Failure in Adults guideline which can be found by visiting **www.icsi.org**, selecting *Guidelines & More* and then searching by *Cardiovascular*. The Heart Failure in Adults Guideline Summary contains an algorithm which is supported by the remaining pages of annotations and evidence. Paper copies of these recommendations are available by calling the MVP Quality Improvement Department at **1-800-777-4793**, ext. 12247. The recommendations will also be available in an update to the MVP Provider Quality Improvement Manual. To view the current edition of the manual, visit **www.mvphealthcare.com** and select *Providers* and then *Providers Quality Improvement Manual*.

Guidelines for the Testing, Management, and Treatment of HIV/AIDS

MVP continues to endorse the Primary Care Approach to the HIV-Infected Patient guideline. This guideline can be found by visiting **www.hivguidelines.org** and selecting *Clinical Guidelines*, then *Adults*, and then *Primary Care Approach to the HIV-Infected Patient*. Additional AIDS guidelines relating to adults, adolescents, and the prevention of HIV transmission during the perinatal period can be found by visiting **www.hivguidelines.org** and selecting *Clinical Guidelines*.

The Clinical Guidelines page was updated to include information and links for HIV testing in pregnancy, the 2010 Amendment to the New York State HIV Testing Law HIV testing to all persons between the ages of 13 and 64 (or younger with risk factors), the 2014 amendment to the New York State HIV Testing Law regarding consent for testing, and testing follow-up. The guideline cover page lists links to all the above topics as well as links to additional references.

MVP Health Care updates its clinical guidelines at least every two years, with the exception to the Guidelines for the Testing, Management, and Treatment of HIV/AIDS, which is reviewed annually. The review process is also initiated when new scientific evidence or national standards are published. Paper copies of these recommendations are available by calling the MVP Quality Improvement Department at **1-800-777-4793** ext 12247. The recommendations will also be available in an update to the MVP Provider Quality Improvement Manual.

To view the current edition of the MVP Provider Quality Improvement Manual, visit **www.mvphealthcare.com** and select *Providers* and then *Providers Quality Improvement Manual*.

Provider Resource Manual Reminder

MVP updates the Provider Resource Manual on a quarterly basis. The effective date of each change is the first of each quarter and all changes are published 30 days in advance. MVP posts all updated sections online. Visit **www.mvphealthcare.com** and select *Providers*, then *Log In* to your account and select *Online Resources*, then *Provider Resource Manual*.

It is very important that providers review the changes on a quarterly basis as there are often policy changes documented in this document.

MEDICAL POLICY UPDATES

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The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the February 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 *Benefit Interpretation Manual* (BIM) located at www.mvphealthcare.com. To access the BIM, log in to your account, visit *Online Resources* and select *BIM* under *Policies*. 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 Professional Relations representative.

Medical Policy Updates Effective April 1, 2016

Allergy Testing: There are no changes to the medical policy criteria. Language regarding food allergen testing and antigen testing limitation has been removed.

Audiologic Screening (OAE): The policy was updated to list criteria for monitoring infants and children with indicators for late onset hearing loss.

Compression Stockings: There are no changes to the medical policy criteria.

Genetic Testing and Counseling: The Genetic Counseling and Testing medical policy was updated with the following:

Chromosomal Microarray Analysis is considered medically necessary for evaluation of a fetus or in a child 13 years or younger with autism disorder, non-syndromic developmental delay or intellectual disability when additional medical criteria is met.

There is a Medicare Variation for GeneSight® Psychotropic and Cologuard™. GeneSight® Psychotropic and Cologuard™ are covered for Medicare products when medical policy criteria are met.

There is a MVP Medicaid Managed Care Variation for genetic testing for Lynch Syndrome.

Genetic cancer susceptibility testing panels or diagnostic genetic testing using panels of genes:

There may be one portion/component of the genetic panel that is medically necessary, however the medical literature does not support the entire genetic panel improves health outcomes and therefore the entire panel is considered investigational.

Diagnostic genetic testing using panels of genes (with or without next generation sequencing), including but not limited to whole genome and whole exome sequencing: Any test/component of the genetic panel that does not meet the criteria listed in the Indications/Criteria section above and therefore the entire genetic panel does not meet medical policy criteria.

Multiplex pharmacogenomics tests/genotyping/mutation analysis (e.g. GeneSight® Psychotropic, Genecept™ Assay, but not limited to the aforementioned) are considered investigational and not medically necessary as they have not been proven to improve health outcomes.

Stool DNA (sDNA) tests (e.g. Cologuard™) are considered investigational and not medically necessary as they have not been proven to improve health outcomes.

Interspinous Process Decompression Systems (IPD): There are no changes to the medical policy criteria.

Intraoperative Neurophysiologic Monitoring: There are no changes to the medical policy criteria. The medical record documentation requirements were updated as follows: Medical record must document the spinal surgical intervention to be performed by the spinal surgeon and documentation of the intraoperative neuromonitoring signals to be performed and interpreted by a certified neurologist is required to support medical necessity for neuromonitoring during the spinal surgical intervention. Also, documentation of a pre-operative assessment of the patient's neurological condition defining the diagnosis and showing the presence of neurological function potentially at risk by the surgery is necessary to support medical necessity.

Lymphedema-Pneumatic Compression Devices, Compression Garments, and Appliances: (Formerly titled Lymphedema Pumps, Compression Garments, and Appliances.) The medical policy was updated to include coverage criteria for segmental pneumatic appliance for use with pneumatic compressor trunk or chest.

Radiofrequency Neuroablation (Rhizotomy) Procedures for Chronic Pain: There are no changes to the medical policy criteria.

Medical Policies for Approval Without Changes in February 2016

Acute Inpatient Rehabilitation
Epidermal Nerve Fiber Density Testing
Obstructive Sleep Apnea: Diagnosis
Sacral Nerve Stimulation

CARING FOR OLDER ADULT PATIENTS

.....

Ask to See Your MVP Medicare Patient's Health Tracker

MVP would like to let you know that our Medicare members receive an *MVP Personal Health Tracker* when they first enroll in an MVP Medicare Advantage plan. Additionally, all currently enrolled MVP Medicare members will soon be receiving another tracker in the mail. We ask that you review it with your patient.

The purpose of this tracker is to help our members keep a record of PCP and specialist visits, what was the reason for the visit, what the member found out during the visit, and what do they need to do. It is also meant to assist in keeping a record of other health care services. Members can list their medications and why they take them, and recommended tests and screenings with results. The tracker also includes information about free programs offered by MVP to help them live well.

Members will be encouraged to work with their doctor to take the best care of themselves.

Talk to Patients About Bladder Control and Prostate Problems

Patients often do not mention incontinence problems with their doctors due to embarrassment and negative social impact. Additionally, many patients incorrectly assume that Urinary Incontinence (UI) symptoms are a part of the normal aging process and there is nothing that can be done to help them.

MVP encourages physicians to talk about bladder control with every patient and to ask all male patients about any prostate concerns they may have. Patients need your help to develop a plan to improve the problems they may have with bladder control. Sometimes simply asking the question can open the door to an important discussion.

Preventing Falls in the Elderly

According to the Centers for Disease Control and Prevention (CDC), approximately one in three individuals age 65 or older sustain a fall each year, but fewer than half talk to their health care practitioner about it. This is an important topic of discussion with the elderly as falls can be largely prevented and hence, injuries such as hip fractures and head trauma can be reduced. There are several key actions a provider can take to help their elderly patients reduce the risk of falling, including:

- Develop a plan with your patient.

- Encourage regular exercise—discuss an exercise program with the patient that focuses on increasing leg strength and balance.
- Review their medications for those that may cause drowsiness or dizziness as a side-effect or in combination with other medications. MVP has developed a chart that you can use, *Medications Considered High-Risk for Older Adults*, which includes medications that should be used with caution in the elderly. Included in this list are medications that may pose additional fall risk as well as possible alternatives. To get the chart, visit www.mvphealthcare.com and select *Providers* and then *Medications Considered High-Risk for Older Adults (PDF)*.
- Ensure they have their vision checked and eyewear adjusted appropriately.
- Discuss tripping/slipping hazards in the home and ways to eliminate them.

MVP offers several tools for practitioners to assist their older adult patients with fall prevention. The *MVP Physician Quality Improvement Manual* includes helpful sheets from the CDC guide, Preventing Falls: How to Develop Community-based Fall Prevention Programs for Older Adults. This guide includes information on how to build an effective program as well as useful tools including:

- Fall Risk Assessment
- Sample Medication Review Form
- Sample Home Fall Prevention Safety Checklist

MVP has also developed tools to assist physicians and their office staff that can be utilized for the above assessments. They can be found in the *Provider Quality Improvement Manual* by visiting www.mvphealthcare.com and selecting *Providers* and then *Provider Quality Improvement Manual*. Additionally, there is a *Fall Prevention Brochure* that can be given to patients, as well as the High-Risk Medication list mentioned above. The *Fall Prevention Brochure* can be downloaded by visiting www.mvphealthcare.com and selecting *Providers*, then *Provider Quality Improvement Manual*, and then *Caring for Older Adults*.

Talk to Patients About Avoiding Hospital Readmission

According to our data, patients admitted for congestive heart failure and sepsis are most likely to be readmitted.

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

Members who are better prepared before their visit will 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 in a timely manner and documenting any changes in medical/surgical history and medications. It is important for primary care physicians and specialists to communicate relevant information to ensure a coordinated approach to the patients care. It is also very important for the patient to see their physician within three to seven 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 the 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 checklist to be used for planning. To view the checklist, visit www.mvphealthcare.com and select *Providers*, then *Provider Quality Improvement Manual*, then *Caring for Older Adults*, and then *Planning a Hospital Stay*.

How Your Patients Respond to the Centers for Medicare & Medicaid Services Health Outcome Surveys (HOS): What is the Physician’s Role?

The Centers for Medicare & Medicaid Services (CMS) requires health plans to monitor the care members receive from their health care providers. As we have discussed in previous editions of this newsletter, the CMS Star Ratings include many measures that are associated with care given by physicians who care for MVP Medicare Advantage members.

Some of the measures are self-reported by your patients through the *Health Outcome Survey (HOS)*

that is mailed to them each Spring. The HOS assesses each Medicare Advantage plan’s ability to maintain or improve the physical and mental health functioning of its beneficiaries and how the physicians work together with their patients to achieve their goals.

The survey includes questions that ask your patients if their Primary Care Physician has talked to them about physical activity, their risk of falls, and urinary incontinence. CMS is expecting that an assessment of these issues is completed and that a treatment plan is in place to improve the quality of life for your patients if any issues are identified.

Assessment of a patient’s physical and mental health is a critical part of any office visit. The MVP CMS star rating of our three Medicare contracts on these measures for the last reporting period are:

- Monitoring physical activity rated 4 and 3 out of 5 stars.
- Reducing fall risk rated 2 out of 5 stars.
- Improving bladder control rated 3 out of 5 stars.
- Improving or maintaining physical health, rated 2, 3, and 4 out of 5 stars.
- Improving or maintaining mental health, rated 3 and 4 out of 5 stars.

CLINICAL QUALITY UPDATE

Gaps in Care

Patient-specific gaps in care will be available in April on the provider portal and updated monthly. The gaps will be populated on the eligibility screen of the provider portal and will be listed under *Patient Alerts* located in the policy detail section of the screen. Two gaps in care will be shown automatically. If there are more than two gaps, there will be a link (*More Patient Alerts*) to the complete list. The gaps in care listed include preventive screening and disease management measures.

If a member is listed as having a gap in care and there is documentation in the medical record that closes the gap, please fax the necessary information to Michael Farina at **518-388-2223**. Please allow at least 30 days for our system to update the changes that are submitted.

The gaps reports in Excel and PDF format for your entire panel will continue to be available. If you would like more information about the gaps in care reports, please contact your clinical reporting coordinator in the following areas:

Rochester

Michael Rosario-McCabe, BS, RN, CCM

585-720-8173

Syracuse/Utica/Binghamton

Elaine Spadafora RN, BSN

315-234-6208

Hudson Valley

Nancy T. Murphy, RN MS

845-897-6061

MVMA

Nicole Gadziala

518-378-0948

PHARMACY UPDATES

Medicare Part D Formulary Exception

To obtain coverage of a drug not included on the formulary or for a quantity greater than allow quantity on drugs with a quantity restriction, a formulary exception must be submitted. The formulary exception request must contain a supporting statement from the prescriber indicating that the request should be approved because:

1. All covered Part D drugs on any tier would not be as effective for the member as the non-formulary drug, or would have adverse effects; or
2. The prescription drug alternatives listed on the formulary have been ineffective or are likely to be ineffective based on both sound clinical and medical evidence, or is likely to cause an adverse reaction or other harm to the member.
3. The number of doses available under a dose restriction for the prescription drug has been ineffective or; based on both sound clinical and medical evidence, and known characteristics of the drug regimen the number of doses available is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

Since a written supporting statement is required, denied formulary exceptions for Part D medications cannot be approved based on a peer-to-peer conversion.

Medicare Part D Prescriber Enrollment

Beginning June 1, 2016, physicians and other eligible professionals who prescribe Part D drugs for Medicare patients must enroll or validly opt-out of the Medicare program in order to prescribe drugs to their patients with Part D prescription drug programs. MVP will be required to notify your Medicare patients that we are unable to cover Part D drugs if you are not enrolled. For more information about the Part D

Prescriber Enrollment, visit www.cms.gov and select *Medicare*, then *Medicare Provider-Supplier Enrollment* under *Provider Enrollment & Certification*, and then *Part D Prescriber Enrollment-Home*.

Electronic Prescribing Mandate

Beginning March 27, 2016, electronic prescribing for both controlled and non-controlled substances is mandatory in New York State, with the following exceptions:

- Non-prescription items such as durable medical equipment do not need to be electronically prescribed.
- Official New York State Prescription forms may be used in the event of a power outage or technical failure.

For additional information, visit www.health.ny.gov/professionals/narcotic/electronic_prescribing/docs/epcs_faqs.pdf.

Male Hypogonadism:

- Natesto nasal gel added to the policy
- Clarified that all testosterone products require prior authorization for Medicaid
- First-testosterone cream/ointment is excluded from coverage
- Testosterone implant pellets manufactured by U.S. Compounding is excluded from coverage

Transgender Policy: ICD-10 codes added

DPP4 Inhibitors: No changes

Glumetza:

- Chart notes are required for documenting failure of formulary alternatives
- Length of approval changed to one year
- Compliance component added for continuation of therapy

Growth Hormone: No changes

Acthar: Multiple Sclerosis criteria updated-member must be treated with Disease-Modifying Agent

Kuvan: No changes

Disposable Insulin Delivery Devices: No changes

Physician Prescription Eligibility: No changes

Prescribers Treating Self or Family Members:

Emergency exception language updated to include situations when access to alternative healthcare provider is not available

Mail Order: Drug categories available at mail order updated

Quantity Limits: Add quantity limit of 60 grams per 30 days of lidocaine/prilocaine and lidocaine/tetracaine cream for Medicaid members

Cuprimine: New policy

Weight Loss Agents:

- Contrave, Evekeo and Saxenda added to policy
- Didrex removed—no longer manufactured

Gaucher’s Disease Type 1 Treatment: Cerdelga added to policy

Formulary Updates for Commercial, Medicaid, and Marketplace Formularies

New Drugs (recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid)

Drug Name	Indication
Tresiba	Diabetes
Onivyde	Metastatic adenocarcinoma of the pancreas
Yondelis	Metastatic liposarcoma
Strensiq	Hypophosphatasia
Genvoya	HIV
Imlygic	Melanoma
Gleostine	Metastatic brain tumor/HL
Belbuca	Pain Management
Cotellic	Melanoma
Tagrisso	NSCLC
Viberzi	IBS-D
Viviodex	OA/RA
Veltassa	Hyperkalemia
Ninlaro	Multiple Myeloma
Empliciti	Multiple Myeloma
Seebri Neohaler	COPD
Utibron Neohaler	COPD

Drugs Added to Formulary (Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace)

Trimipramine Linezolid suspension
Repaglinide/metformin Dutasteride-tamsulosin
Olopatadine ophth

Drugs Removed from Prior Authorization

Aptensio XR Corlanor
Invega Trinza Irenka
Stiolto Respimat



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www.mvphealthcare.com/providerpreferences
to enroll in MVP e-communications.



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MVP Provider Directory

You can search the current MVP Provider Network at www.mvphealthcare.com. Select *Find a Doctor* to search for current primary care professionals and specialists online.

Contacting MVP Professional Relations

MVP Corporate Headquarters	1-888-363-9485
Southern Tier	1-800-688-0379
Central New York	1-800-888-9635
Midstate	1-800-568-3668
Mid-Hudson	1-800-666-1762
Buffalo and Rochester	1-800-999-3920

Denise V. Gonick
President & CEO

We welcome your comments.

Healthy Practices
MVP Health Care, Inc.
Professional Relations Dept.
PO Box 2207
Schenectady, NY 12301



www.mvphealthcare.com

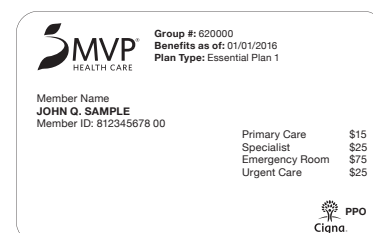
PROFESSIONAL RELATIONS UPDATES

MVP Announces the New Essential Health Plan Product

MVP is introducing the Essential Health Plan Product beginning January 1, 2016. The Essential Health Plan is a new product for New York residents that costs less than most health plans, but offers the same essential health benefits. The new product is available to lower income individuals who do not qualify for Medicaid or Child Health Plus, and it offers a low premium.

The product provides free preventive care services and has no deductible for all non-preventive medical services such as specialist doctor visits, inpatient and outpatient hospital care, tests, and prescriptions.

MVP has a limited network for the Essential Health Plan product. Providers who are participating with these products received a letter and amendment to their MVP contract. If you would like to determine if you or another physician are participating for this product with MVP Health Care, please use the Provider search tool at www.mvphealthcare.com and select *Find a Doctor*.



Sample MVP Member ID card for the **Essential Health Plan** product.

New CMS Place of Service Code

Effective January 1, 2016, The Center for Medicare & Medicaid Services (CMS) has issued a new **place of service code (POS)** for services provided in the outpatient setting that is not located on the hospital campus:

POS 19—"A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization."

POS 19 does not replace place of service 22 which is used for outpatient services provided on the hospitals campus.

POS 22—"A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization."

Reimbursement for services at POS 19 will remain the same as when billed with POS 22. In addition, all medical and payment policies that apply to POS 22 will apply to the new POS 19 for January 1, 2016 dates of service and after. This includes MVP's in-office procedure list. These services will continue to require prior authorization if being billed with POS 19. Providers should specify the POS 19 or POS 22 when submitting prior authorization requests.

Hearing Aid Discount Program

MVP is collaborating with TruHearing™, a national hearing aid benefits company that provides high-quality hearing aids and excellent member service, to offer a hearing aid discount program on certain health plans. Effective January 1, 2016, this new program will offer significant savings and lower members' out-of-pocket costs on hearing aids.

This cost savings program will be extended to Medicare Advantage plan members, individual and small group plan members with a hearing aid benefit for children per the Federal Affordable Care Act (ACA), and MVP members whose employer purchases additional hearing aid coverage. MVP will encourage eligible members to take advantage of hearing aid savings through TruHearing. Please confirm the hearing aid coverage available under your patient's health plan.

HEDIS Spotlight

While traditional HEDIS measures rely on claims report and medical record review, NCQA is introducing a new domain of measures for health plans to report in 2016, Electronic Clinical Data System (ECDS). This set of measures will incorporate additional data from providers' electronic systems and will help to reduce the limitations typically associated with HEDIS reporting. ECDS utilizes data that is automated and accessible by the health care team at the point of care. This may include Electronic Health Records (EHRs), disease registries, or Case/Disease Management systems that allow any provider who interacts with the member to access them.

NCQA is rolling out this new HEDIS domain with the focus on depression measures and the use of a validated tool for assessment and monitoring. The depression measures are described in more detail below.

DMS—Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

(DMS): Compliance is achieved when members (12 and older) with a diagnosis of depression or dysthymia have a PHQ-9 or PHQ-A tool administered at least once in a four-month period.

Two rates are reported:

1. **Inclusion in ECDS**—the percentage of members (12 and older) with a diagnosis of depression or dysthymia who are included in an ECDS.
2. **Utilization of PHQ**—the percentage of members (12 and older) with a diagnosis of depression or dysthymia who have a PHQ-9 or PHQ-A score in their record. Members are those who are included

in the ECDS and have an outpatient encounter during the measurement year.

DRR—Depression Remission or Response for

Adolescents and Adults: This measure focuses on improvement in depression symptoms. Compliance is achieved when members (12 and older) with a diagnosis of depression and elevated PHQ-9 or PHQ-A score have evidence of response or remission within five to seven months of the elevated score.

Four rates are reported:

1. **Inclusion in ECDS**—the percentage of members (12 and older) with a diagnosis of depression or dysthymia who are included in an ECDS.
2. **Depression Remission**—the percentage of members who achieved remission (PHQ score <5) within five to seven months after the initial elevated PHQ score.
3. **Depression Response**—the percentage of members who were not in remission and showed response within five to seven months after the initial elevated PHQ score.
4. **Total**—the sum of the Remission and Response performance rates.

DSF—Depression Screening and Follow-Up for

Adolescents and Adults: Compliance is achieved when members (12 and up) who screened positive for depression receive appropriate follow-up care.

Three rates are reported:

1. **Inclusion in ECDS**—the percentage of members (12 and older) with a diagnosis of depression or dysthymia who are included in an ECDS.
2. **Depression Screening**—the percentage of members who were screened for clinical depression using a standardized tool.
3. **Follow-Up on Positive Screen**—the percentage of members who screened positive for depression and received appropriate follow-up care within 30 days. Follow-up care is defined as one of the following:
 - Receiving a prescription for an anti-depressant medication
 - A follow-up Behavioral Health (BH) encounter/visit (including assessment, therapy, medication management, acute care)
 - A follow-up outpatient visit (with a non-BH provider) with a diagnosis of depression (NOTE: this visit may NOT occur on the same day as the positive depression screen. For a visit on the same day to count there must be documentation of additional screening indicating no depression).

- A follow-up with a case manager with documented assessment of depression symptoms (any encounter that addresses depression symptoms that does **not** occur on same day as positive depression screen).

MVP offers free tools to providers to assist them in screening and management of depression that can be found in the *Behavioral Health* section of the *Provider Quality Improvement Manual*. Visit www.mvphealthcare.com and select *Providers*, then *Provider Quality Improvement Manual*, and then *Behavioral Health*.

For more information on these new HEDIS measures please visit NCQA at <http://ncqa.org/ECDS>.

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
- Address, telephone number, or tax ID number changes

To report demographic changes to MVP, please complete a Provider Demographic Change form. The forms can be downloaded by visiting www.mvphealthcare.com and selecting *Providers*, then *Forms*, and then the appropriate form under *Provider Demographic Change Forms*. Please return the completed demographic change form on letterhead to the appropriate fax number or email below.

East New York and Massachusetts
518-836-3278

eastpr@mvphealthcare.com

Central, Mid-State, or Southern Tier New York
315-736-7002

centralprdept@mvphealthcare.com

Rochester
1-800-684-9286

RocProviderChanges@mvphealthcare.com

Mid-Hudson New York
914-372-2035

MidHudsonprdept@mvphealthcare.com

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

PROVIDER QUALITY IMPROVEMENT MANUAL UPDATE

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The MVP Quality Improvement Committee (QIC) recently re-approved the following enterprise-wide clinical guidelines:

Heart Failure in Adults Guideline

MVP continues to endorse the Institute for Clinical Systems Improvement Heart Failure in Adults guideline found at www.icsi.org/guidelines_and_more/gl_os_prot/cardiovascular/heart_failure_2/heart_failure_in_adults__guideline_.html.

Page 1 of the guideline contains an algorithm which is supported by the remaining pages of annotations and evidence. Paper copies of these recommendations are available by calling the MVP Quality Improvement Department at **1-800-777-4793** extension 12247. The recommendations will also be available in an update to the MVP Provider Quality Improvement Manual. The current edition of the manual is located at www.mvphealthcare.com. Select *Providers* and then *Provider Quality Improvement Manual* under the *Quality Programs* heading.

Guidelines for the Management and Treatment of HIV/AIDS

MVP continues to endorse the guideline, Primary Care Approach to the HIV-Infected Patient. This guideline can be found at www.hivguidelines.org/clinical-guidelines/adults/primary-care-approach-to-the-hiv-infected-patient. Additional AIDS guidelines relating to adults, children, adolescents, and the prevention of HIV transmission during the perinatal period can be found at www.hivguidelines.org/Content.aspx.

HIV testing information is also available at www.health.ny.gov/diseases/aids/providers/testing.

MVP Health Care updates its clinical guidelines at least every two years. The review process is also initiated when new scientific evidence or national standards are published.

MEDICAL POLICY UPDATES

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The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the November and December meetings. 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 *Benefit Interpretation Manual* (BIM) located on www.mvphealthcare.com. To access the BIM, log in to your account, visit *Online Resources* and select *BIM* under *Policies*. 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 Professional Relations representative.

Medical Policy Updates Effective December 1, 2015

Imaging Procedures: Digital breast tomosynthesis has been removed from the MVP Imaging Procedures medical policy as a non-covered procedure.

As of December 1, 2015, MVP Health Care has changed its position on coverage of breast tomosynthesis (CPT code 77061 Digital breast tomosynthesis; unilateral, CPT code 77062 Digital breast tomosynthesis; bilateral and CPT 77063 Screening digital breast tomosynthesis, bilateral [List separately in addition to code for primary procedure]). Services provided on and after December 1, 2015 will be covered.

This change was made after considering the medical literature, opinions of participating providers, and the impact on women's health.

Breast tomosynthesis that is with a screening mammogram (CPT 77063 Screening digital breast tomosynthesis, bilateral [List separately in addition to code for primary procedure]) will follow the same co-payment, co-insurance, and deductible guidelines as other Affordable Care Act services.

Medical Policy Updates Effective January 1, 2016

Custodial Care NEW: This policy addresses custodial care coverage provided within a nursing home for MVP Medicaid members. When skilled nursing facility guidelines are not met, custodial care may be covered as outlined in the policy. All

inpatient custodial nursing home care requires prior authorization. When custodial care within the nursing home is provided in conjunction with daily skilled nursing care or restorative therapy that meets guidelines for skilled nursing facility coverage, the custodial care is covered as part of the member's skilled nursing facility benefit. When skilled nursing facility coverage guidelines are not met, custodial care may be covered according to the criteria outlined in this policy.

Medical Policy Updates Effective February 1, 2016

Alopecia/Wigs/Scalp Prosthesis: There are no changes to the medical policy criteria.

Autism Spectrum Disorders NY: There are no changes to the medical policy criteria.

Blepharoplasty/Browlift/Ptosis Repair: There are no changes to the medical policy criteria.

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

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

Clinical Guidelines Development, Implementation, and Review: There are no changes to the medical policy process.

Cochlear Implants and Osseointegrated Devices: The bone conduction threshold measurements for unilateral and bilateral osseointegrated devices were updated to reflect the measurements to the specific device.

Dental Care Services: Medical Services for Complications of Dental Services: There are no changes to the medical policy criteria.

Electrical Stimulation Devices and Therapies: The medical policy is updated to state that electrical tumor treatment field therapy is considered investigational and therefore not covered. Cefaly device for treatment/prevention of migraine headaches is considered investigational and therefore not covered.

Erectile Dysfunction: The Medicaid variation was updated to state vacuum systems only covered for diagnosis of impotence. The Medicare variation now states vacuum systems not covered.

Extracorporeal Shockwave Therapy: The Medicare variation now states extracorporeal shock wave therapy is not covered.

Ground Ambulance/Ambulette Services: The Medicare Variation was updated to state "when criteria for paramedic intercept services are not met the claim will be denied administratively."

Hearing Aid Services: Medicare variation added to state that coverage is available through TruHearing™ as of January 1, 2016.

Investigational Procedures, Devices, Medical Treatments, and Tests: This policy outlines all mentioned procedures considered Experimental and Investigational and not covered. The following devices and tests have been added to the policy:

- Bioimpedance Devices for Detection of Lymphedema (e.g. ImpediMed LDex™)
- Hydrogel Spacing for Radiotherapy of Prostate Cancer (e.g. SpaceOAR)
- Invasive Congestive Heart Failure Monitoring (e.g. CardioMEMS)
- Multi-biomarker for Rheumatoid Arthritis (Vectra DA®) there is a Medicare Variation. Vectra DA is covered for Medicare members only when policy criteria is met.
- Rupture of Membranes (ROM) testing in Pregnancy (AmniSure ROM Test [PAMG-1], ROM Plus® Fetal Membrane Rupture test [PP12, AFP], and Actim® PROM [GFBP-1] test for Detection of Fetal Membrane Rupture)
- Serum Antibodies for the Diagnosis and Monitoring of Inflammatory Bowel Disease (e.g. Anser IFX and Anser ADA)
- Shoulder joint resurfacing

Lenses for Medical Conditions of the Eye: There are no changes to the medical policy criteria.

Orthotic Devices: The policy was updated to state elastic support garments do not meet the definition of a brace and are not covered.

Psychological Testing: Computerized psychological testing is now covered when psychological testing policy criteria are met.

Therapeutic Footwear for Diabetics: There are no changes to the medical policy criteria.

Wheelchairs (Manual): There are no changes to the medical policy criteria.

Medical Policies for approval without changes in November 2015:

- Speech Generating Devices
- Botulinum Toxin Treatment
- Obstructive Sleep Apnea: Surgical

CARING FOR THE ELDERLY

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Talk to Patients About Bladder Control and Prostate Problems

Patients often do not mention incontinence problems with their doctors due to embarrassment and negative social impact. Additionally, many patients incorrectly assume that Urinary Incontinence (UI) symptoms are a part of the normal aging process and there is nothing that can be done to help them.

MVP encourages physicians to talk about bladder control with every patient and to ask all male patients about any prostate concerns they may have. Patients need your help to develop a plan to improve the problems they may have with bladder control. Sometimes simply asking the question can open the door to an important discussion.

Preventing Falls By the Elderly

According to the Centers for Disease Control and Prevention (CDC), approximately one in three individuals age 65 or older sustain a fall each year, but fewer than half talk to their doctor about it. This is an important topic of discussion with the elderly because falls can often be prevented, reducing injuries such as hip fractures and head trauma.

There are several key actions you can take to help your elderly patients reduce the risk of falling:

- Develop a plan with your patient.
- Ask your patient, directly, if they have fallen or felt unsteady on their feet.
- Encourage regular exercise—discuss an exercise program with your patient that focuses on increasing leg strength and balance.
- Review their medications for those that may cause drowsiness or dizziness as a side-effect or in combination with other medications.
- Ensure they have their vision checked and their eyewear is adjusted appropriately.
- Discuss tripping/slipping hazards in the home and ways to eliminate them.

MVP offers several tools to assist practitioners in fall prevention. The MVP Physician Quality Improvement Manual includes helpful sheets from the CDC guide, *Preventing Falls: How to Develop Community-Based Fall Prevention Programs for Older Adults*. This guide includes information on how to build an effective program as well as useful tools:

- Fall Risk Assessment
- Sample Medication Review Form

- Sample Home Fall Prevention Safety Checklist

MVP has developed some tools to assist physicians and their office staff that can be utilized for the above assessments. Visit www.mvphealthcare.com and select *Providers*, then *Provider Quality Improvement Manual (PQIM)* in the *Quality Programs* section, and then *Caring for Older Adults*. In addition to assessment tools, you also will find a brochure for your patients about fall prevention and a link to the Beer's List of high-risk medications.

PHARMACY UPDATES

Prior Authorization for Nexium and Esomeprazole

Nexium now requires prior authorization for Commercial and Exchange members.

Esomeprazole may be obtained without prior authorization but does have a quantity limit of two capsules per day.

Pharmacy Policy Updates Effective January 1, 2016

Select Hypnotics: Hetlioz and Belsomra added to policy

Xyrem: Criteria updated to include 18 years and old; doses greater than 9 grams per night added as exclusion

Multiple Sclerosis Agents: Added Plegridy and Lemtrada

Gralise: Removed related policy (Qutenza)

Benlysta: Updated indications

Government Programs Over-the Counter (OTC)

Drug Coverage: No changes

Patient Medication Safety: Changed PBM from Express Scripts to Cvs/caremark

Cystic Fibrosis (selected agents for inhalation): Removed Kalydeco from policy

Cystic Fibrosis (select oral agents): New policy-requiring prior authorization for Kalydeco and Orkambi

Lidocaine (topical) Products-New policy for Medicaid members: Lidocaine cream, ointment, gel, lotion, jelly, and patches will require prior authorization

Glumetza NEW: Glumetza will require prior authorization

Immunoglobulin Therapy: HyQvia added to policy

Prostate Cancer: Removed criteria that patient must no longer be responding to docetaxel

Pharmacy Policy Updates Effective February 1, 2016

Lyme Disease/IV Antibiotic Treatment: No changes

Onychomycosis: Jublia and Kerydin added to policy

Antibiotic/Antiviral (oral) Prophylaxis: No changes

Zyvox: Linezolid tablets added to policy

Antimalarial Drugs: Policy archived

Solodyn: No changes

Overactive Bladder (oral) Treatment: Policy archived

Intranasal Corticosteroids: Flonase and fluticasone nasal spray will no longer be covered due to availability of OTC version

Valchlor: Added NCCN criteria to policy

Quantity Limits for Prescription Drugs

- Antimalarial Drugs added to policy
- Quantity limits removed for smoking cessation products for Medicaid members

2016 Formulary Changes

2016 Formulary Exclusions for Commercial Members

The following medications will require medical exception approval.

Excluded NSAIDs	Formulary Alternatives
Arthrotec	Generic NSAIDs
Duexis	Celebrex
Naprelan	Flector
Pennsaid	Voltaren Gel
Vimovo	Zipsor
Excluded Gastrointestinal Agent	Formulary Alternatives
Relistor	Movantik
Excluded Narcotic Antagonist	Formulary Alternatives
Zubsolv	Generic agents Bunavail Suboxone
Excluded Respiratory Agents	Formulary Alternatives
Proair HFA	Ventolin
Tudorza Pressair	Spiriva
Proventil HFA	Spiriva Respimat
Incruse Ellipta	
Xopenex HFA	

2016 Formulary Changes for Medicaid Members

The following medications will be non-formulary and require prior authorization.

Non-Formulary Diabetic Agents	Formulary Alternatives
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Byetta	Victoza
Kombiglyze	Januvia
Onglyza	Tanzeum
	Tradjenta

2016 Formulary Changes for Medicare Part D Members

The following is not a complete list of changes. Please refer to the 2016 Medicare Formulary document by visiting www.mvphealthcare.com and selecting *Providers*, then *2016 Covered Formulary Drug List & Updates*, and then *2016 MVP Health Care Comprehensive Medicare Part D Covered Drugs (Formulary)* (published 10/2015) under the *Pharmacy* heading.

The following medications will be non-formulary and require an exception request.

Non-Formulary Respiratory Products	Formulary Alternatives
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Dulera	Advair
Foradil	Serevent
ProAir	Anoro Ellipta
Tudorza	Incruse
Spiriva	Arnuity Ellipta
Arcapta	Flovent
Asmanex	Ventolin
Qvar	Breo Ellipta
	Ellipta

The following medications will now require prior authorization for Medicare Part D members for 2016.

- Amitriptyline*, Doxepin*, and Imipramine*
- Digoxin 0.25mg*
- Aubagio

**Considered high risk by CMS, consider formulary alternatives.*

Formulary Updates for Commercial, Medicaid, and Marketplace Formularies

New Drugs (recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid)

Drug Name	Indication
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Zarxio	Neutropenia
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Drug Name	Indication
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Addyi	Hypoactive sexual desire disorder
Synjardy	Type 2 diabetes
Envarsus XR	Prophylaxis of organ rejection
Tolak	Multiple actinic or solar keratosis
Odomzo	Basal cell carcinoma
Lonsurf	Colorectal cancer
Aristada	Schizophrenia
Varubi	Chemotherapy induced N/V
Durlaza	Risk reduction in prior stroke or cardiac patients

Drugs Added to Formulary (Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace)

Rivastigmine patch
Fluvastatin XL
Paliperidone ER
Pimozide
Dutasteride

Drugs Removed from Prior Authorization

Lyparza	Rytary
Evotaz	Duopa
Movantik	Ibrance
Incruse Elipta	Savaysa Opdivo
Lenvima	Farydak Toujeo
Evekeo	Glyxambi
Sotylize	Signifor LAR
Mircera	Cresemba
Liletta	Jadenu



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