HealthyPractices™

MVP HEALTH CARE

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

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Vermont

In this Issue:

MVP Provider Directory

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

$ Un-Cashed Checks?

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

MVP Professional Relations

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

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

We welcome your comments.

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MVP HEALTH CARE
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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 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

(Continued on page 2)

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

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 pregnancy[1]. 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 births[2].

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.

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.

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 Zolinza.

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
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% opth drops-Tier 1 for Marketplace

Drugs Removed from Prior Authorization

Rayaldee
Kyleena
Vemlidy
Soliqua
Taytulla
Lartruvo
Adlyxin
Basaglar

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