HEALTHY PRACTICES™

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New York/MVMA

IN THIS ISSUE

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We welcome your comments.

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PROFESSIONAL RELATIONS UPDATE

In-Office Procedure List Update

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.

Effective July 1, 2015, MVP will be changing how we deny these procedures. 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 then choose *Online Resources* on the left hand side of the page.

Low Back Pain—Should You Order an X-Ray, MRI, or CT Scan?

Back pain is one of the most common reasons individuals visit their doctor each year. Luckily, most episodes of low back pain will resolve on their own within about four weeks. Generally, tests such as x-rays, CT scans, or MRIs are **not** recommended during this time, unless specific red flags are present. Patients may be inclined to ask for one, but keep in mind the following tips you can provide:

- Imaging carries risks—you should try to minimize exposure to radiation as it can build up over time.
- Imaging tests are expensive and can actually lead to unnecessary additional testing and surgery or other invasive procedures.

Most back pain will respond to conservative treatment. Below are some **first aid steps** you can encourage patients to try at home:

- **Stay active**—bed rest is usually not recommended and can actually lengthen the pain episode by causing stiffness and increased weakness. Walking is a light activity that is usually good for those with low back pain—it keeps your blood flowing and your muscles strong.

- **Use heat and/or cold**—applying a heating pad to the area or taking a warm bath can help as heat aids in relaxing muscles. Applying ice may also help pain by relieving swelling and inflammation.
- **Take over-the-counter medication**—anti-inflammatories like ibuprofen (Motrin®) or pain relievers such as acetaminophen (i.e., Tylenol®) generally help low back pain by reducing swelling and pain.

If the patient's back pain has lasted longer than six weeks, or if they have red flags present, it might be time to order one of these tests. Common *red flags* include a serious fall or accident along with history of osteoporosis or use of immunosuppressive therapy, change in bladder or bowel function, loss of feeling or weakness in legs, unexplained weight loss, fever over 100.4 degrees for more than 48 hours, or loss of reflexes.

For more information, MVP's *Low Back Pain Guideline* is available at **www.mvphealthcare.com** by selecting *Providers*, then *Quality*, and finally *Provider Quality Improvement Manual*.

Satisfaction Survey Reminder

MVP sends out an annual survey to gauge provider's satisfaction with the health plan. We have changed our format of this survey for 2015. We will be doing two surveys, one in the spring and another in the fall. The spring survey was sent out in mid-April and will be used to gauge providers' office satisfaction with MVP's utilization management process. The fall survey will be used to gauge the office's satisfaction with other areas of interest within MVP such as the claims process and the website. Please share the survey within the practice to ensure that the various sections are completed by the individual with the most experience in a specific survey area. Provider offices that complete these surveys will be entered into a drawing to win one of four $50 VISA gift cards; a separate drawing will be done for each of the two surveys. MVP values your feedback and appreciates your efforts in completing this survey.

Smoking Cessation for Medicaid Enrollees

Many people who use tobacco want to quit, but need help. There are tools and support available if your patients ask about ways to quit smoking. Medicaid expanded coverage of Smoking Cessation Counseling (SCC) to all Medicaid beneficiaries on March 1, 2014 and has extended this benefit to all Medicaid enrollees. The expanded benefit allows each member a total of eight tobacco cessation counseling sessions during any 12 continuous months, in addition to coverage of two, 3-month courses of prescribed smoking cessation medications or over-the-counter nicotine replacement products per year. Physicians are urged to also advise patients that telephone and online quit support is available for free from the New York State Smokers' Quitline at **1.866.NY.QUITS** (1.866.697.8487) or **www.nysmokefree.com**.

No prior authorization is needed to provide or bill for SCC services. However, practices may call 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 in 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 ICD-9-CM diagnosis code, 305.1 tobacco use disorder, *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).
- 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. which is available at **www.health.ny.gov**.

MVP Medicaid and Child Health Plus Now Offered in Select East and Central New York Counties

MVP is pleased to offer Medicaid Managed Care and Child Health Plus programs in Albany, Jefferson, Rensselaer, Saratoga, Schenectady, and Warren counties, effective December 1, 2014.

MVP strongly recommends checking member eligibility at **www.mvphealthcare.com/provider** at least monthly. When checking the MVP Member ID card, the plan type at the top of the ID card for these programs will say:

- **MVPM**: MVP Medicaid Managed Care
- **MVPMS**: MVP Medicaid Managed Care SSI
- **MVPC**: MVP Child Health Plus

MVP uses a dedicated formulary for Medicaid Managed Care. The MVP Commercial Formulary is used for Child Health Plus. To view the Formularies, visit **www.mvphealthcare.com/provider** and select *Pharmacy*, and then *Formularies with Copay Descriptions*.

The MVP Participating Provider network for MVP Medicaid Managed Care and MVP Child Health Plus is available at **www.mvphealthcare.com**. Not all MVP providers participate in all of MVP's plans. To determine the MVP plans in which you currently participate, please use the *Find a Doctor* tool on our website. Under the *Guest* tab, select an MVP plan and enter your information. You will need to do this for each MVP plan. If your name appears in the search results, you are a participating provider for members who are enrolled in that MVP plan.

If you have any questions, please contact the MVP Customer Care Center for Provider Services at **1-800-684-9286**.

MVP Provider Website Enhancements

You talked, we listened! Recent feedback from you, our providers, has indicated that the claims inquiry screen on the provider website does not provide enough detail on paid and denied claims. In our effort to improve your experience, we have made some enhancements to the functionality to ensure providers can access the information they need regarding their claims without having to call MVP's Customer Care Center. The enhancement includes less clicks to get to the information you need and a better understanding of claim denials and adjustments. *Log In* at **www.mvphealthcare.com/provider** and review these enhancements. Also check back often as more improvements will be coming throughout 2015!

OB/GYN Change in Reimbursement

Effective August 1, 2015, MVP will no longer be accepting the modifier TH when billed at the first prenatal appointment. This will result in providers not being reimbursed the $300 of the *global* OB fee at the beginning of the patient's care. MVP is not changing the reimbursement amount providers receive; however, they will not receive their full reimbursement until after the delivery of the baby.

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 *Provider* and then the appropriate form under *Provider Demographic Change Forms*. Please fax the completed demographic change form on letterhead to **518-836-3278**, or email your demographic changes to **professionalrelations@mvphealthcare.com**. For more information, see section 4 of the *Provider Resource Manual*.

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 at **www.mvphealthcare.com** by selecting *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, telephone 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
PO Box 2207
625 State Street
Schenectady, NY 12301
1-888-687-6277 (TTY 1-800-662-1220)

CARING FOR OLDER ADULTS

Talk With Your Patients

MVP wants our Medicare Advantage Plan members, your patients, to live well and stay healthy. With that in mind, we remind them every year of the importance of preventive care. We also provide them with information, such as a special preventive care section in our member newsletter, to educate and assist them.

We encourage members to talk with you about:

- Blood pressure testing, monitoring and control
- Body Mass Index (BMI) assessment
- Breast cancer screening—clinical breast exam or schedule a mammogram as recommended
- Cholesterol screening and control
- Colorectal cancer screening—schedule a colonoscopy as recommended
- Depression screening
- Diabetes tests and monitoring: HbA1C; kidney monitoring, cholesterol (LDL), and dilated eye exam by an eye care provider
- Testing and treatment of osteoporosis (especially important after a fall)

It is also important for them to talk to you about some issues that are more difficult:

- Bladder control problems/concerns and intervention where needed
- Physical activity (maintain or increase current level) and develop a plan
- Problems taking prescribed medications
- Risk of falling—are they at risk, have they had a recent fall, how falls can be prevented

Our goal is to work together with you and your staff to help our Medicare members understand the importance of these tests and also to follow through on your recommendations.

Alternatives to High-Risk Medications

The Centers for Medicare & Medicaid Services (CMS), The American Geriatrics Society, and the National Committee for Quality Assurance (NCQA) caution the use of certain high-risk medications in patients 65 years and older. Use of high-risk medication can increase morbidity and mortality, decrease quality of life, and lead to preventable health care costs.

We ask that you review the medications your patients are taking today. If they have a prescription for any medication that has been identified as high-risk for older adults, please consider changing to a potentially safer medication. If you would like MVP to supply a report of prescriptions that your patients who are MVP Medicare Advantage members have filled, please contact Michael Farina, Associate Director Clinical Reporting at **mfarina@mvphealthcare.com**.

A New Program For MVP Medicare Advantage Members

MVP will begin offering a new end-of-life program during the second quarter of 2015 called *Living Well*. MVP is partnering with Vital Decisions, an organization that provides this service to eligible Medicare Advantage members.

The Living Well program is a telephonic, patient-centered health care counseling service provided by Vital Decisions. There is no cost to your patient for this program as MVP offers it to our members who are dealing with difficult health care situations.

Vital Decisions' specially trained counselors work with individuals and their families, through a series of telephone conversations to help educate, discuss, and work through the important topics of advance care and life planning during this difficult time. The counselor's role is to help individuals identify their quality of life priorities and preferences, and help

them communicate effectively with their family and physicians so that care planning decisions can be made with their preferences in mind.

The counselors at no time interfere with the physician-patient relationship, never provide medical advice, or provide an opinion regarding the care plan or team in place. Experience has demonstrated that the counseling program enhances physician-patient communication as well as the overall relationship.

It is MVP's goal to support our members during the difficult journey of advanced illness. We believe that members who engage in high quality communication in tandem with well-developed decision making processes are more likely to obtain the care most closely aligned with their values.

CLINICAL GUIDELINES UPDATES

Hypertension Treatment Guidelines

MVP has adopted 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 (JNC 8). A copy of the JNC 8 can be found at **jama.jamanetwork.com** by searching for the title of the report. This is an update to the JNC 7.

Key Messages

Treat to blood pressure target levels:

- < 140/90 mm Hg for ages < 60 years
- < 150/90 mm Hg for ages ≥ 60 years with no diabetes and no kidney disease

Lifestyle modifications such as healthy diet, weight control, and regular exercise have the potential to improve blood pressure control.

Initial antihypertensive treatment:

- In the general non-black population, including those with diabetes, initial antihypertensive treatment should include a thiazide-type diuretic, calcium channel blocker (CCB), angiotensin-converting enzyme inhibitor (ACEI), or angiotensin receptor blocker (ARB).
- In the general black population, including those with diabetes, initial antihypertensive treatment should include a thiazide-type diuretic or CCB.
- In the population aged ≥ 18 years with CKD (including all CKD patients with hypertension regardless of race or diabetes status), initial (or add-on) antihypertensive treatment should include an ACEI or ARB to improve kidney outcomes.

Smoking Cessation Guideline

MVP Health Care, as part of its continuing Quality Improvement Program, adopted the Department of Health and Human Services Smoking Cessation guideline. Recommendations include tips for assessing a patient's readiness to quit and suggested medications available for patients who want to stop smoking. There have been no changes to the key recommendations. The full guideline is available at **www.ahrq.gov/professionals** by selecting *Clinical Guidelines and Recommendations* under *Clinicians & Providers*, and *then Treating Tobacco Use and Dependence*.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the April 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, 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, 2015

Lymphedema Pumps, Compression Garments, Appliances: The medical policy was updated to include criteria for Continuation of Use for lymphedema pumps. A variation for MVP/Hudson Health Plan Medicaid products has be added to state Segmental pneumatic appliance for use with compressor, trunk or chest, or full legs and trunk are considered not medically necessary.

Hip and Shoulder Joint Resurfacing ARCHIVED
The Hip and Shoulder Joint Resurfacing medical policy is archived.

Obstructive Sleep Apnea: Diagnosis: The Epworth Sleepiness Scale ≥ 10 has been removed from the

Indication/Criteria section. Abbreviated cardio-respiratory sleep study to acclimate an individual to PAP (e.g., PAP-Nap study is listed as an exclusion as it is considered experimental/investigational an as there is limited published medical literature that PAP-Nap studies improve adherence to therapy.

Sacral Nerve Stimulation: A Medicare Variation has been added for percutaneous tibial nerve stimulation. Percutaneous tibial nerve stimulation is covered for Medicare members with a diagnosis of over active bladder (OAB) as a third-line treatment when all the medical policy criteria is met.

Medical Policies for Approval Without Changes in April 2015

- Allergy Testing and Allergen Immunotherapy
- Ambulatory Holter Monitor/30-day Cardioverter Event Recorder
- Cardiac Output Monitor by Thoracic Electrical Bioimpedence
- Cardiac Procedures
- Compression Stockings
- Electrical Stimulation Devices & Therapies
- Genetic Counseling and Testing
- Hip Surgery for FAI
- Home Uterine Activity Monitoring
- Infertility Advanced Services
- Interspinous Process Decompression Systems (IPD)
- Light Therapy for Seasonal Affective Disorder
- Obstructive Sleep Apnea: Devices
- Procedures for the Management of Chronic Spinal Pain
- Radiofrequency Neuroablation Procedures for Chronic Pain
- Rhinoplasty
- Speech Therapy (Outpatient) and Cognitive Rehabilitation
- Wheelchairs (Electric and Power Scooters)

PHARMACY UPDATES

CVS/caremark Reminder

Effective January 1, 2015, CVS/caremark became MVP's Pharmacy Benefit Manager (PBM) for retail, mail, and specialty prescriptions.

What does this mean for providers and members?

- MVP members can have prescriptions filled at any pharmacy that is participating with CVS/caremark nationwide. This network is **not** limited to CVS pharmacies.
- MVP members wishing to obtain prescriptions via mail order will use the CVS Caremark Mail Service Pharmacy.
- In addition, all specialty medications should be obtained from the CVS Caremark Specialty Pharmacy at **1-866-444-5883**. Medicare and Medicaid members also have the option of obtaining their specialty medications from a contracted specialty pharmacy.

Prolia/Xgeva-Medicare Part D

Effective June 1, 2015 Prolia and Xgeva will require prior authorization to determine coverage under Medicare Part D or Part B. Medications shipped from a specialty pharmacy to a provider's office and administered would typically be covered under Medicare Part B. Prior authorization forms can be faxed to **1-800-665-7924**.

Onco360

Onco360 is an oncology pharmacy in the MVP network that provides an alternative option for practices that do not wish to buy and bill medications. Along with billing MVP directly for a member's medications, Onco360 will also work with patient assistance programs when appropriate. For more information, please contact Onco360 at **1-877-662-6633**.

Nexium

Due to the limited number of suppliers of generic Nexium (esomeprazole) and the potential for drug shortages, both the brand and generic products will be tier 2 for Commercial and Marketplace formularies and non-formulary tier 3 on the Medicaid formulary. Esomeprazole will be non-formulary for Medicare Part D and if approved via a non-formulary request will take a tier 4 copay.

Pharmacy Updates Effective May 1, 2015

Gaucher's Disease

- Ceredase removed

Acthar

- Azathioprine removed as an option for second-line therapy for Iga Nephropathy

Kuvan

- Phenylalanine concentrations updated per guidelines
- Criteria/indication for infants added

Male Hypogonadism

- Medicaid variation clarified

Growth Hormone Therapy

- Valtropin removed
- Levodopa, clonidine, or propranolol tests used in diagnosis of GHD no longer recommended and were removed from policy
- Added in the transition between childhood and adult dosing, a one month drug holiday should be taken, in which time, appropriateness of therapy should be reevaluated.

Infertility Drug Therapy

- Luveris removed
- Clomiphene reduced to six cycles per pregnancy-12 per lifetime

Mail Order

- Exclusion for short acting beta-agonist inhalers removed

Hepatitis C Treatment

- Infectious disease, gastroenterologist, and hepatologist prescribing requirement removed
- Criteria for no IV drug or alcohol use in previous six months and chronic compensated liver disease removed
- Documentation must be provided to support the use of other treatment regimens over Harvoni

Pharmacy Program Administration

- Updated to reflect change to CVS/caremark

Antipsychotics (Select) Oral for Depression

- Prior authorization requirement for Medicaid and Child Health Plus removed

Quantity Limits for Prescription Drugs

- Buprenorphine/naloxone quantity limit changed to 90 tablets per 30 days for Medicaid
- Insulin quantity limit for Medicaid removed

Policies Reviewed and Approved Without Any Changes

- DPP4 Inhibitors
- Epinephrine Autoinjector
- Weight Loss Agents
- Physician Prescriptions Eligibility
- Prescribers Treating Self or Family Members
- Compound (Extemporaneous) Medications

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
Orbactiv	Skin infection
Contrave	Weight loss
Vitekta	HIV
Akynzeo	Antiemetic
Ofev	IPF
Esbriet	IPF
Trulicity	Type 2 diabetes
Belsomra	Insomnia
Afrezza	Diabetes
Obizur	Hemophilia
Zerbaxa	Intra-abdominal infections
Rapivab	Influenza
Viekira Pak	Hepatitis C
Blincyto	ALL
Keytruda	Melanoma
Xigduo XR	Type 2 diabetes
Mitigare	Gout
HyQvia	PID
Lemtrada	MS
Reyataz Powder	HIV

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

Tacrolimus Oint
Amlodipine/valsartan/HCT
Valganciclovir tablet
Guafacine ER
Ivermectin
Testosterone gel 25mg/2.5gm
Celecoxib
Clobetasol spray

Drugs Moved to Non-formulary (Tier 3)

Celebrex
Vivelle-Dot

Drugs Removed from Prior Authorization

Zontivity
Zykadia

* Medical drug
† Must be obtained from CVS Specialty Pharmacy
^ Tier 2 on Marketplace (Exchange) formulary
# Prior authorization required
D Diabetic copay
QL Quantity limits apply

MVP HEALTH CARE

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NY/MVMA

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