HEALTHY PRACTICES™

West

VOLUME 8
NUMBER 1
JAN./FEB. 2013

THIS NEWSLETTER CONTAINS INFORMATION THAT PERTAINS ONLY TO MVP-PARTICIPATING HEALTH CARE PROVIDERS.

in this issue

contacting professional relations

MVP Corporate Headquarters	1-888-363-9485
Buffalo	716-839-1366, x1000
Rochester	Call your representative or Provider Services at 1-800-999-3920

David W. Oliker
Chief Executive Officer

Healthy Practices
is a bi-monthly publication
of the Corporate Affairs Dept.

comments

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

MVP® HEALTH CARE

www.mvphealthcare.com

Healthy Practices will now be delivered to your email

To reduce our impact on the environment and minimize the amount of mail that we send to our providers, MVP Health Care® is converting our printed newsletters to email. If you would like to enroll in MVP e-communication and receive your next communication by email, please complete this form: **www.mvphealthcare.com/providerpreferences**. If you have any questions or choose to opt out at any time, please email **ecommunications@mvphealthcare.com**.

RADIOLOGY/RADIATION PROGRAM UPDATES

Advanced imaging procedure scheduling via CareCore National

As of October 29, 2012, MVP Health Care expanded its affiliation with CareCore National (CCN) to include a concierge service to assist members with scheduling advanced radiology services (MRI, MRA, CAT and PET scans). To assist with the transition, please review the following process details.

HEALTH CARE PROVIDERS WHO REQUEST IMAGING SERVICES

General process flow

- Ordering providers must provide their individual NPI and not their group NPI when calling CCN with a prior authorization request.
- Upon approval of a prior authorization request, CCN will contact the member to schedule the service.
- CCN will send the authorization approval to the requesting provider, to the member and to MVP to support claims payment.
- Servicing providers should verify that they are the servicing provider on the authorization prior to providing services to a member to avoid denial of payment.
- Referring or servicing providers may not call CCN to change the servicing provider; this must be done by the patient.

What if you have a history of sending patients to a certain servicing provider?

If you have historical case data* for a particular modality (MRI, CT, PET) ordered at an accredited servicing provider, CCN will ask if you want to send the member to that site. If so, that site will be automatically set for the member and the case will not go through CCN's scheduling process.

**Note – historical case data exists when the referring provider has referred at least three or more cases to a specific servicing provider fifty percent or more of the time for a specific service based on prior authorizations.*

Do emergent imaging services require prior authorization?

- Emergent services do not require prior authorization.
- If the procedure is being performed in the office setting, however, authorization is required for the procedure.
- If an emergent procedure is performed prior to receiving authorization, providers have **three business days** to call CCN to obtain authorization.
  - CCN will still review the case to determine if clinical criteria for emergent services are met prior to approving the authorization.
  - The member scheduling process is bypassed in this situation.

- If the procedure is emergent and performed in the emergency room, then authorization is not required.

If you need an urgent authorization, it is possible to bypass the CCN scheduling process by following these steps.

- **PRE-SERVICE**
  - Contact CCN to obtain an authorization prior to the service being performed and indicate at the **beginning** of the call that the request is **"urgent"**. If the case meets the urgent clinical criteria, the scheduling process will be bypassed. Please note that if this is not indicated at the beginning of the call with CCN, the authorization will not bypass member scheduling.
  - As of November 19, 2012, urgent cases may be submitted through CCN's web portal. You will be asked "is this clinically urgent?"; select "yes" for the case to follow the "urgent" process with CCN.
  - Urgent cases cannot be submitted to CCN via fax. Providers must call or go online for urgent cases.
- **POST-SERVICE**
  - Health care providers have **three business days** post-service to call in an urgent authorization request. You must indicate that the case was "urgent". The case will be reviewed to determine whether urgent clinical criteria were met before the authorization is approved.

When is the need for an advanced imaging service considered urgent?

The National Committee for Quality Assurance (NCQA) criteria state that urgent cases include the following:

- A delay in care could seriously jeopardize the life or health of patient or the patient's ability to regain maximum function.
- The opinion of the health care provider, with knowledge of member's medical condition, indicates that a delay in care would subject the member to severe pain that cannot be adequately managed without the care or treatment requested in prior authorization.

When can you request a peer-to-peer review?

You always have access to a medical director at CCN; simply request a peer-to-peer review while on the phone with CCN.

HEALTH CARE PROVIDERS WHO PERFORM IMAGING SERVICES (SERVICING PROVIDERS)

What do servicing providers need to do differently now that the scheduling service is active?

Most practices already make it a habit to confirm that an authorization is in place for a procedure prior to performing it. Before setting an appointment with a MVP member, it will now be especially important to check the CCN website **(www.carecorenational.com)** or speak with a representative at CCN to verify that an authorization is in place.

MVP has implemented a new policy effective October 1, 2012, as communicated in the July/August *Healthy Practices*, which requires all freestanding radiology facilities to be credentialed with MVP to be considered participating providers. If you are not credentialed with MVP, members will not be able to choose your location to have their services performed. Freestanding facilities that see members who do not have out-of-network benefits will not be reimbursed for services provided.

The new policy also requires that all physician offices that are performing MRI/MRA, CT Scans or PET Scans in their office must have a valid ACR or IAC accreditation. Providers that do not have ACR or IAC accreditation will not be listed as servicing providers on a member's authorizations for services and all claims will be denied unless a member has out-of-network benefits.

MEMBERS/PATIENTS

General process flow

- Upon clinical approval of an authorization request, CCN will contact patients approved for a high-tech imaging service, walk them through the process of selecting where the service will be performed and offer to connect them with the chosen site for an appointment.
- Members will receive information on providers' participation with MVP (in- or out-of-network) and will be instructed to obtain out-of-pocket cost information from MVP, if desired.
- Member requests for specific, participating facilities will be honored.

When will members be contacted to schedule an appointment once an imaging procedure is approved?

- To ensure timely appointments for members, the scheduling process begins within **30 minutes** of exam approval.
- CCN will attempt to reach members by phone over the course of two days to schedule the radiology service. If that outreach is not successful, the member is auto-assigned a place of service by CCN. CCN will send a letter to the member with information about the assigned location.
- When CCN is able to reach the member and a location is chosen, you will receive a fax indicating the name of the servicing location the member has chosen.
- If CCN is unable to reach the member and auto-assigns them, you will receive a fax indicating if the member has been auto-assigned and the name of the servicing location to which they are assigned.

What if a member doesn't want to go to the imaging location at which CareCore National schedules them?

CCN will attempt to reach members by phone over the course of two days to schedule the radiology service. If that outreach is not successful, the member is auto-assigned a place of service by CCN. CCN will send a letter to the member with information about the assigned location.

- If CCN reaches the member by phone, member requests for specific, participating providers with ACR or IAC accreditation will be honored.
- If CCN auto-assigns a place of service and communicates that assignment via a letter, members may call CCN upon the receipt of the letter to change the location for their procedure. Member requests for specific, participating providers with ACR or IAC accreditation will be honored.

What if a member does not get CCN's phone call for scheduling and receives the letter from CCN with a location assigned for their procedure AFTER they undergo the procedure somewhere else?

As a servicing provider, please check your patient's authorization to determine if a prior authorization is on file with CCN. Also check to see if you are listed as the servicing provider on the authorization. If you are not, you must ask the member to change the location on the authorization prior to performing the procedure. You may assist members with this process by calling CCN with the patient to request the site of service be changed to your location. If the servicing location is not changed on the authorization and you perform the procedure, the claim will be denied. The member will be held harmless.

If an authorization is not on file and the service is performed, the claim will be denied, but the member will be held harmless. This is the same process that is in place today.

What if a member completes the scheduling process with CCN but at last minute decides to go to a different site to have the procedure performed? Will the claim still be paid?

Servicing providers are aware they must have an authorization in place prior to seeing a member. The claim will be denied, but the member will be held harmless. However, the member may call CCN to request a change to a different servicing location at any time. Providers should follow the process above and assist the member in calling CCN to change the servicing location.

If the servicing location is not changed on the authorization and you perform the procedure, the claim will be denied. The member will be held harmless.

Radiation therapy reminder

Effective October 29, 2012, MVP has partnered with CCN to perform prior authorization for radiation therapy treatment. Providers must contact CCN and submit radiation therapy treatment plans for authorization. The list of procedures that require prior authorization is listed on MVP's website at **www.mvphealthcare.com**. To access the list, log in to your account, visit *Online Resources* and click *Radiation Therapy CPT Code List* under *Resources*. Please note that for radiation therapy, authorization requests are for a patient's overall treatment plan, not just for a specific CPT code on the list.

Questions?

If you have questions about MVP's radiology scheduling or radiation therapy program, please refer to our online Q&A document. To access the Q&A, log in to your account at **www.mvphealthcare.com** and go to *Online Resources*. You may also contact your MVP Professional Relations Representative.

PROFESSIONAL RELATIONS UPDATES

Evolution Health—a new product for 2013

MVP Health Care is introducing a new product in 2013 that provides an affordable way for the members to receive high quality health care at a low price. Evolution Health from MVP offers members a lower cost share when services are performed in the office setting over a freestanding or outpatient facility for specific diagnostic services, rehabilitation and therapies. If services are performed in an office setting (Place of Service 11), the specialist copay applies. For other facility settings, the member's amount owed can be up to a $500 copay. If a $500 copay is collected at the time of service and the allowed amount for the service is less than $500, providers will need to reimburse the member for the balance. Please remember to check each patient's benefit information online so you can refer them to the most affordable place of service.

Free training on depression screening

Major depression is one of the most common mental disorders in the U.S.—almost 17 percent of adults will experience depression at some point in their lives. Depression often co-occurs with other conditions and is associated with decreased adherence to medical regimes. Despite effective treatments for depression, many individuals often delay seeking treatment or do not receive an adequate trial of medication or physician follow-up. The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression in children (ages 12 and up) and adults in the general population when adequate systems are in place to assure appropriate follow-up. Although there are many easy-to-use tools for depression screening, many offices do not have a process in place that supports the primary care practitioner in doing the appropriate screening and follow-up. Systems may include:

- Designating support staff to perform the screening using standardized questions and scoring it for the clinician. The PHQ tool is an example of a tool that is brief and easy to administer and score.
- Providing education to the patient, including side effects of medications to watch for and when to notify the clinician.
- Scheduling follow-up visits and reviewing expectations with patient.
- Assisting with referrals to specialized behavioral health treatment.

To improve depression screening in primary care, MVP is partnering with its behavioral health service provider, ValueOptions®, to offer free training to help you:

- learn about the impact of depression for members with co-morbid, chronic medical conditions;
- learn about depression screening tools and their usage in the PCP setting;
- identify the risk factors and red flags when screening for depression; and
- learn about ValueOptions' physician consultation phone line and referral process.

If you are interested in learning more about how to develop a system for depression screening and follow-up in your office, please email **northeastservicecenter@valueoptions.com**.

MVP's depression care program to be managed by ValueOptions®

Effective January 1, 2013, MVP Health Care will retire its Depression Care Program. At that time, depression management will be handled by ValueOptions, a trusted partner of MVP and leader in behavioral health services. The ValueOptions program name is "Depression Identification and Management".

High-risk members currently enrolled in MVP's Depression Care Program will continue their care management though MVP. Members currently enrolled in MVP's low-risk mailing program will transition over to ValueOptions. Members may continue to self-refer by contacting the MVP Population Health Management Department at **1-866-942-7966**.

Providers also may continue to contact the MVP Population Health Management Department at **1-866-942-7966** for depression care referrals. MVP will then work with ValueOptions for member outreach and enrollment.

This change will be reflected in the updated *Provider Resource Manual*, available March 2013.

If you have any questions about this transition, please contact the MVP Customer Care Center for Provider Services.

More information is available on the ValueOptions website at **www.valueoptions.com/mc/eMember/tipsAndResources2.do**

Code of ethics and business conduct summary

Introduction

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, contractors and delegated entities with a formal statement of MVP's commitment to the standards and rules of ethical business conduct. All network providers, vendors, contractors and delegated entities are expected to comply with the following standards.

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 and delegated entities 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 Databases

MVP, its Government Programs contractors and delegated entities are required to review the exclusion databases maintained by the Department of Health and Human Services Office of Inspector General (OIG), the General Services Administration (GSA) and the New York State Office of Medicaid Inspector General (OMIG). 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. MVP, its contractors and delegated entities are required to comply with federal and state requirements regarding the employment of and contracting with any excluded individuals or entities.

Prohibiting the Acceptance of Gifts

The Code 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). MVP's 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, **1-877-835-5687**, where suspected fraud and abuse issues can be reported directly by internal and external sources.

Fraud, Waste and Abuse Training

MVP's contractors that support its Medicare products are required to provide FWA training to their employees, subcontractors and downstream entities. The Centers for Medicare & Medicaid Services (CMS) provides a standardized FWA training module. This module is available through the CMS Medicare Learning Network at **www.cms.gov/MLNProducts**. The use of the CMS training module is optional and contractors may use another fully compliant training program that addresses the CMS FWA training requirements. Contractors 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 DMEPOS are deemed to have met the FWA training requirements.

Reporting Suspected Violations

MVP provides an Ethics & Integrity Hotline for reporting suspected violations of the Code or of its legal requirements. The Ethics & Integrity Hotline at **1-888-357-2687** is available for employees, vendors and contractors to report suspected violations anonymously. Ethics Point manages MVP's confidential reporting system and receives calls made to the Hotline. Ethics Point 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 MVP's Compliance Program.

MEDICAL POLICY UPDATES

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 click *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 February 1, 2013

Breast Reconstruction Surgery: Language has been added under Documentation Requirements to include partial mastectomy, which also includes lumpectomy as required by the NYS Department of Health mandate.

Cochlear Implants and Osseointegrated Devices: There are no changes to the medical policy.

Dermabrasion: There are no changes to the medical policy. Dermabrasion is considered to be cosmetic and, therefore, is not medically necessary.

Durable Medical Equipment: The following language was added to the policy:

- Replacement of lost, stolen or irreparably damaged items requires a new physician order documenting the medical necessity; and documentation should include statements indicating the reason for the replacement.
- Under supplies, "quantity limits may apply" was added.
- Language was updated under the Medicare Variation and is consistent with Medicare guidelines that a prescription drug benefit is not required for diabetic supplies and insulin when billed through the pharmacy benefit manager. A prescription drug benefit is required for insulin and supplies under the Medicare Part D prescription benefit. A prescription drug benefit is not required for medications deemed Part B. Disposable medical supplies are covered in accordance with Medicare coverage criteria.

Hyperbaric Oxygen Therapy (HBO): The policy follows Medicare guidelines. Language was added to clarify that documentation must indicate that the member has tried and failed negative pressure wound therapy prior to requesting HBO (see the MVP Medical Policy Negative Pressure Wound Therapy Pumps).

Indirect Handheld Calorimeter: There are no changes to the medical policy. There is insufficient evidence in the peer-reviewed literature that indirect handheld calorimeters provide superior outcomes; therefore, they are considered not medically necessary. Specialist opinion is in agreement with the policy as written.

Ovacheck® Proteomic Pattern Analysis of Blood
NEW POLICY: There is insufficient evidence in the peer-reviewed literature that Ovacheck results in proven beneficial outcomes. Therefore, it is considered investigational.

Prosthetic Devices (Upper and Lower Limb): Language regarding functional capabilities was updated under Documentation Requirements. The prosthetist's record must be corroborated by the patient's information in the physician's medical record. Microprocessor controlled knee requires documentation that the member is at a Functional Level 3 or above as determined by the Amputee Mobility Predictor test score. Criteria were also added under Upper Limb that myoelectric upper arm prosthetic components may be considered when criteria in the policy are met.

Spinal Fusion—Lumbar: There are no changes to the medical policy. The policy follows InterQual® criteria.

Varicose Veins of the Lower Extremities: Language was added that "it must be documented in the medical record that the patient must have failed a trial of conservative, non-surgical management for at least six (6) weeks when criteria in the policy are met." Conservative therapy includes the following NSAIDS, unless not tolerated: exercise (e.g., walking, bicycling, swimming, leg lifts, leg squats); avoid standing or sitting in one position for more than 30 minutes; elevate legs (take several short breaks daily to elevate legs above the level of the heart); compressive hose; weight loss (if applicable); avoid alcohol and high sodium foods; and avoid sitting with legs crossed.

List of medical policies reviewed and approved in 2011 recommended for approval without changes in November 2012:

- Autism Spectrum Disorders NH
- Dynamic Splinting Devices
- Experimental or Investigational Procedures
- Hyaluronic Acid Derivatives
- Neuropsychological Testing
- Private Duty Nursing
- Psychological Testing
- Radiofrequency Ablation for Pain (Rhizotomy)

Please refer to the coding section on the policies to identify any code changes (e.g., new, deleted) or codes no longer requiring prior authorization for a specific policy. Each policy grid defines the prior authorization requirements for a specific product.

PHARMACY UPDATES

Enteral therapy New York

As published in previous versions of *Healthy Practices*, MVP will be making changes to how our members obtain enteral nutrition products. Effective **January 1, 2013**, members will be required to obtain enteral formulas from a participating pharmacy. They may obtain enteral formulas from home infusion vendors, but those vendors must be able to bill online

through Express Scripts (formerly Medco), MVP's pharmacy benefits manager. A list of all enteral products that will adjudicate through Express Scripts can be found in the *Benefit Interpretation Manual*. If a product is not listed, it will require prior authorization from MVP's pharmacy department effective January 1, 2013. Requests should be submitted on the *Prior Authorization Request Form for Medication* and faxed to the phone number on the bottom of the form. If a request for the enteral formula is denied as not medically necessary, MVP will not cover ancillary supplies and services, including but not limited to pumps, poles, feeding kits, nursing and all home infusion services associated with the administration of the enteral formula. Claims for supplies and services will be subject to retrospective review.

Therapeutic class changes

Upon review of select therapeutic classes, the Pharmacy & Therapeutics committee approved the following changes. These changes do not apply to MVP Medicare business. All impacted members and providers will receive a letter if further action is required.

- **Antidiabetic agents**—Janumet XR will be added to the formulary. Onglyza and Kombiglyze XR will be removed from the formulary and require prior authorization effective April 1, 2013.
- **Inhaled corticosteroids**—Qvar will be added to the formulary. Flovent will be removed from the formulary. Prior authorization will be required for non-formulary agents Alvesco and Flovent effective April 1, 2013.
- **Inhaled corticosteroids/LABA combinations**—Dulera will be added to the formulary. Advair will be removed from the formulary and require prior authorization effective April 1, 2013.
- **Urinary anticholinergics/antispasmodics**—Toviaz and Vesicare will be added to the formulary. Prior authorization will be required for non-formulary agents effective April 1, 2013.

Policy updates (effective February 1, 2013)

Compounded (Extemporaneous) Medications

- Examples of compounds that are considered experimental were added. They include, but are not limited to, compounded bioidentical hormones, verapamil topical gel, estriol, nebulized anti-infectives for nasal administration and ketamine topical gels.

Crohn's Disease & Ulcerative Colitis

- Criteria added for step through Humira prior to Remicade for ulcerative colitis. Language was added to allow for medical coverage for Cimzia for Medicare members.

Erythropoietic Agents

- Omontys was added.
- Obsolete language was removed.

Gout

- Criteria updated to request baseline LFTs prior to Uloric therapy.

Government Programs OTC

- Language added to indicate that some enteral formulas may require prior authorization.

Immunoglobulin Therapy

- Gammaked was added.
- Medicare variation was updated.

Makena

- Step through compounded 17P is no longer required.
- Language added to address Makena use in eligible women at 26 weeks and 6 days.
- Short cervix and no history of preterm birth were added as exclusions.

Nulijix NEW

- Member must be 18 years or older.
- Medication must be prescribed by a kidney transplant specialist or nephrologist.
- Must be sero-positive for Epstein-Barr virus.
- Must be used in combination with other drugs, as indicated in the prescribing information.
- Must have contraindications to standard therapy regimens.

Patient Medication Safety

- Medicaid variation was added and Medicare variation was updated.

Proton Pump Inhibitors

- Language updated to reflect possible association with increased risk of c. difficile.

Quantity Limits (QL)

- Staxyn was added with a QL of 4 tablets in 30 days. Zuplenz was added with a QL of 21 films in 30 days.

The following policies were reviewed and approved without any changes to criteria:

- Cialis for BPH
- Constipation and IBS
- Cosmetic Agents
- Dermatologicals for Inflammation
- Psoriasis

Formulary updates for Commercial and Option members

New drugs

(recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Option/MVP Option Family)

Drug Name	Indication
Binosto	Osteoporosis
Bosulif	Chronic myelogenous leukemia
Forfivo XL	Major depressive disorder
Kyprolis*	Multiple myeloma
Myrbetriq	Overactive bladder
Qsymia	Weight reduction
Prepopik	Colon cleansing
Rayos	Anti-inflammatory-immunosuppressive
Sklice	Head lice
Stivarga	Colon cancer
Stribild	HIV-1 infection
Tudorza Pressair	COPD
Xtandi	Prostate cancer
Zaltrap*	Colon cancer

**Medical drug*

Generic drugs added to Formulary (Tier 1)

diclofenac-misoprostol (Arthrotec)
entacapone (Comtan)
methylphenidate CD (Metadate CD)
oxcarbazepine (Trileptal Oral Susp)
sildenafil (Revatio)
tiagabine (Gabitril)

Drugs removed from the Formulary (effective February 1, 2013)*

Emend
Metadate CD
Nultyely

**Affected members will receive a letter if further action is required (i.e., contacting the prescriber for a formulary alternative)*

Drugs added to the Formulary

Combivent Respimat
Suboxone (all dosage forms)

Drugs removed from prior authorization

(all medications are non-formulary, Tier 3 unless otherwise noted)

Intermezzo	Janumet XR	Omeclamox
Potiga	Zioptan	

CREDENTIALING UPDATES

HIV/AIDS specialist designation

The New York State Department of Health requires health insurers to be able to identify physicians that provide services to patients with HIV/AIDS and to make this information available to the health plan's members in their directories.

Physicians (MDs and DOs) who meet the following criteria may choose to be designated as an HIV/AIDS specialist in MVP's provider directories (via our online *Find a Doctor* search and in hard copy by request to the Customer Care Center):

- Meets the definition of an HIV-experienced physician according to the HIV Medicine Association (HIVMA); OR
- Has HIV Specialist status accorded by the American Academy of HIV Medicine (AAHIVM); OR
- Is providing ongoing, direct clinical ambulatory care of at least twenty HIV infected persons who are being treated with antiretroviral therapy in the preceding twelve months.

Physicians who meet these criteria and wish to be identified as HIV/AIDS Specialists in MVP directories should complete and return a HIV/AIDS Specialists attestation form. The form is on the MVP website at **www.mvphealthcare.com/provider/credentialing.html** under *Miscellaneous Credentialing Information.*

Physicians who are approved for designation as an HIV/AIDS Specialist will be required to re-attest to their continued ability to meet the above criteria on an annual basis, as well as their willingness to maintain their designation as an HIV/AIDS Specialist.

Urgent care center continuity of care/transfer protocol requirements

Urgent Care Centers (UCCs) are required to provide MVP with a Hospital Transfer Protocol, pursuant to a determination made by the MVP Credentials Committee. Each UCC's protocol is subject to review and approval by the MVP Credentials Committee and must include:

- A description of how the UCC facilitates the emergent transfer of patients to a hospital setting.
- A description of the communication that takes place between the UCC and the receiving hospital, including:
  - That a provider-to-provider conversation occurs prior to the patient transfer, that the communication is documented in the patient's medical record and applicable medical records are provided to the hospital; AND
  - Written OR verbal communication between the Urgent Care Center and the patient's primary care provider which includes the name of the hospital to which the patient is referred/transferred.

Once a facility's transfer protocol is approved by the MVP Credentials Committee, physicians providing urgent care services at that facility will be allowed to use the protocol at the time of credentialing/recredentialing as a method of meeting the MVP physician criteria for continuity of care.

Urgent Care Centers that have not yet submitted a hospital transfer protocol should fax a copy of the protocol to **518-386-7200**. The deadline for submission is February 15, 2013. An *Urgent Care Center Hospital Transfer Protocol* cover sheet is available on the MVP website at **www.mvphealthcare.com/provider/credentialing.html** under *Facility Credentialing*.

Anesthesiology hospital transfer protocol for office-based anesthesia services

The MVP Credentials Committee has determined that anesthesiologists who provider office-based surgery anesthesia services and who do not maintain hospital privileges are required to provide MVP with a *Hospital Transfer Protocol*.

Each protocol is subject to review and approval by the MVP Credentials Committee and must include:

- A description of the anesthesiologist that will facilitate the emergent transfer of patients to a hospital setting.
- A description of the communication that takes place between the anesthesiologist and the receiving hospital/physician, including:
  - That a provider-to-provider conversation occurs, that the communication is documented in the patient's medical record, and applicable medical records are provided to the hospital; AND
  - That roles and responsibilities are clearly defined, as to which physician is responsible for coordinating an anesthesia-related emergency or a surgery-related emergency.

Once an anesthesiology group's transfer protocol is approved by the MVP Credentials Committee, all anesthesiologists providing services for the group will be allowed to use the protocol at the time of credentialing/recredentialing to meet the MVP physician continuity of care criteria.

Anesthesiology groups that have not yet submitted a hospital transfer protocol should fax a copy of the protocol to **518-386-7200**. The deadline for submission is February 15, 2013. An *Anesthesiology Hospital Transfer Protocol* cover sheet is available on the MVP website at **www.mvphealthcare.com/provider/credentialing.html** under *Facility Credentialing*.

QUALITY UPDATES

Upcoming medical record reviews to support health plan regulatory reporting requirements

HEDIS® and New York State QARR data collection begins in February 2013. 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 by contract 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 (DFR), formerly known as the Banking and Insurance, Securities and Health Care Administration (BISHCA).

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 2013, reviews will include the assessment of the clinical performance in the following areas:

- Adolescent Immunizations, including meningococcal vaccine, tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) and Human Papillomavirus Vaccine (HPV) for female adolescents
- Adult BMI assessment
- Cholesterol management for patients after acute cardiovascular event
- Colorectal cancer screening
- Comprehensive diabetes care
- Controlling high blood pressure
- Prenatal, post-partum and frequency of ongoing prenatal care

MVP has again contracted with Interim HealthCare® for registered nurses to help our QI staff collect data from medical records. A MVP Quality Improvement staff or Interim HealthCare 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 let us know.

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 Jeannette Flynn Weiss, RN, MS in the MVP Quality Management Department at **585-327-5733** or **1-800-933-3920, ext. 45733**.

UTILIZATION MANAGEMENT UPDATES

Updates to ClaimsXten™ clinical editing software

Effective February 17, 2013, MVP Health Care will continue to enhance its clinical editing application, McKesson ClaimsXten, with the implementation of additional editing rules incorporated in the Waste and Abuse Knowledge Pack that was introduced in 2012. (Nov/Dec 2011 and May/June 2012 *Healthy Practices, FastFax* late March 2012.)

Included in this update:

- CMS injection quantity review of select pharmaceutical HCPS codes for diagnosis and quantity editing. **The next page is a list of J-codes with the acceptable diagnosis and quantity limits.** Claims for J-codes with diagnoses and/or quantities other than those listed will be denied with the code V5, unless a prior authorization is approved by MVP.
- Diabetic supply frequency editing of select diabetic supply codes to reflect typical utilization of that supply based upon MVP payment policy.

MVP has been utilizing ClaimsXten since 2009 to audit claims more efficiently. The sources of ClaimsXten's correct coding standards include, but are not limited to:

- American Medical Association (AMA)
- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- National Correct Coding Initiative (NCCI).

J-codes with the acceptable diagnosis and quantity limits

CODE	DESCRIPTION	RULE†
J1745	Remicade Refer to Arthritis, Inflammatory Biologic Drug Therapy OR Crohn's Disease & Ulcerative Colitis, Select Agents Benefit Interpretations	• Maximum Units = 90 • Will only be reimbursed when billed with the following diagnosis codes: 555.x, 556.x, 696.0,696.1,714.0,714.1,714.2, 714.30, 714.31, 714.32, 714.33, 720.0
J9035	Avastin	• Maximum Units = 135 • Will only be reimbursed when billed with the following diagnosis codes: 153.x, 154.0, 154.1, 154.8. 162.x, 189.0, 189.1, and 191.x
J2505	Neulasta	• Maximum Units = 1 • Will only be reimbursed when billed with the following diagnosis codes: 288.00, 288.01, 288.02, 288.03, 288.04, 288.09
J9310	Rituxan Refer to the Arthritis, Inflammatory Biologic Drug Therapy Benefit Interpretation	• Maximum Units = 10 • Will only be reimbursed when billed with the following diagnosis codes: 200.xx, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.40, 202.41, 202.42, 202.43, 202.44, 202.46, 202.47, 202.48, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 204.00, 204.01. 204.02, 204.10, 204.11, 204.12, 446.0, 446.4, 714.0, 714.1, 714.2
J9355	Herceptin	• Maximum Units = 72 • Will only be reimbursed when billed with the following diagnosis codes: 151.x, 174.x, 175.x
J3487	Zometa	• Maximum Units = 4 • Will only be reimbursed when billed with the following diagnosis codes: 174.x, 198.5, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 275.42, 731.1, 733.00, 733.01, 733.02, 733.09, 733.90
J2469	Aloxi	• Maximum Units = 10 • Will only be reimbursed when billed with the following diagnosis codes: 787.01, 787.02, 787.03
J9041	Velcade	• Maximum Units = 31 • Will only be reimbursed when billed with the following diagnosis codes: 200.xx and 203.xx
J2323	Tysabri Refer to the Crohn's Disease & Ulcerative Colitis, Select Agents OR Tysabri for Multiple Sclerosis Benefit Interpretations	• Maximum Units = 300 • Will only be reimbursed when billed with the following diagnosis codes: 340 and 555.x
J2353	Sandostatin Depot	• Maximum Units = 30 • Will only be reimbursed when billed with the following diagnosis codes: 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 253.0, 259.2, 787.91
J2778	Lucentis	• Maximum Units = 5 • Will only be reimbursed when billed with the following diagnosis codes: 250.50, 250.51, 250.52, 250.53, 362.07, 362.30, 362.52, 362.83
J0129	Orencia Refer to Arthritis, Inflammatory Biologic Drug Therapy Benefit Interpretation	• Maximum Units = 100 • Will only be reimbursed when billed with the following diagnosis codes: 714.0, 714.1, 714.2, 714.30, 714.31, 714.32, 714.33
J3488	Reclast Refer to the Osteoporosis Medications, (Injectables) Benefit Interpretation	• Maximum Units = 5 • Will only be reimbursed when billed with the following diagnosis codes: 731.0, 733.00, 733.01, 733.02, 733.03, 733.09
J2405	ondansetron	• Maximum Units = 32 • Will only be reimbursed when billed with the following diagnosis codes: 787.01, 787.02, 787.03
J9171	Taxotere	• Maximum Units = 154 • Will only be reimbursed when billed with the following diagnosis codes: 151.x, 162.x, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.9, 175.x, 185, 195.0

†Quantity limits, when not specific to the drug package label or Benefit Interpretation, are calculated using 90kg body weight and/or 5'6" height

CLAIMS UPDATES

Submitting electronic replacement and void claims

MVP Health Care's claims processing system recognizes claim frequency codes on professional electronic claim transactions (ANSI 837P transactions) and institutional (UB-04) electronic claim transactions (ANSI 837I transactions). Using the appropriate code will indicate that the claim is an adjustment of a previously adjudicated (approved or denied) claim. The claim frequency codes are as follows:

Claim Frequency Code	Description
1	Indicates the claim is an original claim.
7	Indicates the new claim is a replacement or corrected claim — the information present on this bill represents a complete replacement of the previously issued bill.
8	Indicates the claim is a voided/canceled claim.

PROFESSIONAL CLAIM SUBMISSION:

Replacement Claims

Replacement claims (sometimes referred to as corrected claims or recall claims) submitted electronically will assist with prompt and accurate processing. A replacement claim is any claim that has a change to the original claim (e.g., changes or corrections to charges, procedure or diagnostic codes, dates of service, member name). Corrected claims may be submitted immediately. When a replacement claim is being submitted, you may submit the correction electronically with a "7" as the frequency code.

An example of the ANSI 837P file containing a replacement claim, along with the required REF segment and Qualifier in Loop ID 2300–claim information, is provided below.

Claim Frequency Code

↑

CLM* 1 2345678*500***11:B :**7***Y*A*Y*I*P~

REF*F8*(Enter the Claim Original Reference Number)

In the above illustration, "11" (segment and data element CLM05-1) is an example of the place of service, which is used to identify where services were performed. "B" (CLM05-2) is the place of service code qualifier, which is required in ANSI v501 0 to identify the place of service codes for professional claims. "7" (CLM05-3) is the claim frequency code.

The value F8 must be reported in the REF segment, element 01 and the original claim number in the REF segment, element "02" in the 837 claims submission. *(If the original claim number is not included, the submission will be rejected.)*

The replacement claim will replace the *entire* previously processed claim. Therefore, when submitting a correction, send the claim with all changes *exactly* how the claim should be processed.

Examples:

1. A claim was submitted with procedure codes 99213, 88003 and 77090. The 88003 should have been 88004. An electronic replacement claim should be submitted for the line that needs to be corrected, along with the appropriate frequency code of 7 with procedure codes 99213, 88004 and 77090. This indicates to MVP that all charges need to be deleted and the claim will then be processed with procedure codes 99213, 88004 and 77090.
2. A claim was submitted with procedure codes 99214, 70052 and 99213. Procedure codes 70052 and 99213 were submitted in error and need to be removed. An electronic replacement claim should be submitted with frequency code 7 and procedure code 99214. This claim will then be adjusted to remove 70052 and 99213; only procedure code 99214 will be included in the claim.

Note:

- If a charge was left off the original claim, please submit the additional charge with all of the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim.
- Paper Adjustment requests will still be required for additional documentation submissions or timely filing.
- Claims that were not previously accepted (returned or rejected) should be re-submitted as an original claim.
- The correct member number (and suffix) needs to be submitted with the recalled claim, otherwise, the submission will error.

Void Claims

If a claim was submitted to MVP in error and needs to be voided, the claim to be voided should be submitted *exactly* as it was submitted previously, along with frequency code "8" to indicate that the claim should be voided.

Examples:

- Incorrect payer ID
- Incorrect subscriber ID
- Incorrect billing provider

Void only claims should be submitted with an "8" as the third position of the bill type (XX8). The bill type must be reported in the CLM segment, element "05" in the 837 claim submission. The first two positions of the bill type are reported in the sub-element 1 and the third position is reported in the sub-element 3.

Example:

Claim Frequency Code

↑

CLM* E12345678900*500***21:A :**8***Y*A*Y*Y****N~

The value F8 must be reported in the REF segment, element 01 and the original claim number in the REF segment, element "02" in the 837 claims submission. If the *original claim number* is not included, the submission will be rejected.

Example:

REF*F8*(Enter the Claim Original Reference Number)

Note:

- You may wish to follow a void bill with a bill containing the correct information when a payer is unable to process a replacement to a prior claim. The appropriate frequency code must be used when submitting the new bill.

INSTITUTIONAL (UB-04) CLAIMS SUBMISSION:

Replacement Claims (UB-04)

Corrected claims should be submitted with a "7" as the third position of the bill type (XX7). The bill type must be reported in the CLM segment, element "05" in the 837 claim submission. The first two positions of the bill type are reported in the sub-element 1 and the third position is reported in the sub-element 3.

Example:

Claim Frequency Code

↑

CLM* E12345678900*500***21:A :**7***Y*A*Y*Y****N~

The value F8 must be reported in the REF segment, element 01 and the original claim number in the REF segment, element "02" in the 837 claims submission. If the original claim number is not included, the submission will be rejected.

Example:

REF*F8*(Enter the Claim Original Reference Number)

The replacement claim will replace the *entire* processed claim. Therefore, when submitting a correction, send the claim with all changes exactly how the claim should be processed.

Note:

- If a charge was left off the original claim, please submit the additional charge with all of the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim.
- Paper adjustment requests will still be required for additional documentation submissions or timely filing.
- Claims that were not previously accepted (returned or rejected) should be re-submitted as an original claim.
- The correct member number (and suffix) needs to be submitted with the recalled claim, otherwise, the submission will error.

Void Only Claims

Void only claims should be submitted with an "8" as the third position of the bill type (XX8). The bill type must be reported in the CLM segment, element "05" in the 837 claim submission. The first two positions of the bill type are reported in the sub-element 1 and the third position is reported in the sub-element 3.

Example:

Claim Frequency Code

↑

CLM* E12345678900*500***21:A :**8***Y*A*Y*Y****N~

The value F8 must be reported in the REF segment, element "01" and the *original claim number* in the REF segment, element "02" in the 837 claims submission. If the original claim number is not included, the submission will be rejected.

Example:

REF*F8*(Enter the Claim Original Reference Number)

Note:

- You may wish to follow a void bill with a bill containing the correct information when a payer is unable to process a replacement to a prior claim. The appropriate frequency code must be used when submitting the new bill.

CLAIMS UPDATE QUICK REVIEW GRID

Question	Definition	Examples	How to Submit Claims
What is a replacement (or corrected or recall) claim? (type of bill ending in 7)	A replacement claim is sent when an element of data on the claims was either missed or needs to be corrected on the claim.	• Incorrect date of service (DOS) • Incorrect units • Procedure code missing • Diagnosis code change or addition • Revenue code changes • Line being added • Change to injury date • Change to related cause code • Change to place of service • Change to rendering provider with no billing provider change	If claim was previously processed on Facets and was billed via paper, send in CARF. If claim was previously processed on Facets and billed electronically, follow EDI/MVP replacement claim submission guidelines. Claims that require timely filing review or additional documentation need to be submitted via CARF.
What is a voided claim? (type of bill ending in 8)	When identifying elements change, a void submission is required to eliminate the previously submitted claim.	• Payer information change • Subscriber information change • Billing provider change • Patient information change • Statement covers period • Patient did not want insurance billed • Bill type changes from IP to OP or OP to IP.	Whether original claim was submitted by paper or electronically, the void may be sent electronically. The void should be sent along with the new original claim. Follow EDI/MVP submission guidelines.

MEDICARE UPDATES

CMS Star program raises the bar

Articles in past issues of *Healthy Practices* have introduced the Star program and the expectations that the Centers for Medicare & Medicaid Services (CMS) have of MVP and the physicians who contract with MVP to care for our Medicare members. CMS is now rating the MVP Preferred Gold HMO and GoldAnywhere PPO products based on clinical outcome measures, member satisfaction (access and service) and administrative oversight. Currently, the list includes 47 unique measures.

For many of these clinical measures, MVP and our physicians are rated at a 5-star level across our contracts. This is the highest CMS rating (star ratings are 1 - 5). Our current ratings, however, also point out opportunities for improvement in a number of clinical measures. These measures are listed below.

MVP will continue to work with physicians, office staff and members to improve these results. Please think about ways to improve these results within your own practice. If you are interested in getting further information about these clinical measures or if you have suggestions as to how we might improve, please contact: Mary Orr, Associate Director, Medical Quality Management, Government Programs, at **585-327-2284** or **morr@mvphealthcare.com**.

CMS STAR PROGRAM: CLINICAL MEASURES ON WHICH MVP IS FOCUSING FOR IMPROVEMENT

Clinical Measure (Source)	Description
Annual Flu Vaccine (Member survey data)	Percent of plan members aged 65+ who got a vaccine (flu shot) during the prior flu season.
Breast Cancer Screening (Claims data)	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.
Cardiovascular Care – Cholesterol Screening (Claims data)	Percent of plan members with heart disease who have had a test for "bad" (LDL) cholesterol within the past year.
Diabetes Care – Eye Exams (Claims & medical record review data)	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.
Diabetes Care – Kidney Disease Monitoring (Claims & medical record review data)	Percent of plan members with diabetes who either had a urine micro-albumin test during the measurement year, or who had received medical attention for nephropathy during the measurement year.
Diabetes Care – Blood Sugar Control (Claims & medical record review data)	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.
Drug Plan – members 65 and older receive a prescription for certain drugs with a high risk of side effects (Pharmacy claims data)	Percent of Medicare Part D beneficiaries 65 years or older who received prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.
Improving Bladder Control (Member survey data)	Percent of members with a urine leakage problem who discussed the problem with their doctor and got treatment for it within six months.
Improving or Maintaining Mental Health (Member survey data)	Percent of all plan members whose mental health was the same or better than expected after two years.
Improving or Maintaining Physical Health (Member survey data)	Percent of all plan members whose physical health was the same or better than expected after two years.
Monitoring Physical Activity (Member survey data)	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.
Osteoporosis Management (Claims data)	Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within six months.
Reducing the Risk of Falling (Member survey data)	Percent of Medicare members 65 years of age or older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.
Rheumatoid Arthritis Management (Claims data)	Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.
Plan All-Cause Readmissions (Claims data)	Percent of plan members 65 years of age or older discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.
Using the kind of blood pressure medication that is recommended for people with diabetes (Pharmacy claims data)	Percent of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB) medication or renin angiotensin system (RAS) medication.

CMS principles for evaluation and management documentation

The Center for Medicare & Medicaid Services (CMS) has general principles for evaluation and management documentation. Medical record documentation assists physicians and other health care professionals in evaluating the patient's treatment.

The General Principles for medical record documentation are:

- The medical record must be complete and legible—include the date of service and the name of the provider
- The reason for the encounter, relevant history, physical examination findings and prior diagnostic test results must be stated
- Include the medical necessity of the services provided
- Provide an assessment, clinical impression and diagnosis
- Detail the medical plan of care
- Past and present diagnoses should be noted
- Appropriate health risk factors should be identified
- The patient's progress, response and changes in treatment, and any revisions of a diagnosis should be documented

The documentation needs to be clear and concise; it is critical to providing patients with quality care and also required in order for providers to receive accurate and timely payment for services rendered. Remember, the medical records need to give a chronological report of the patient's care, along with pertinent facts and observations about the patient's history. The services should be documented during the encounter or as soon as possible after the encounter.

It is your responsibility to ensure the submitted documentation accurately reflects the patient's diagnosis and the services provided are justified. If you have questions you can email **ymonroe@mvphealthcare.com** or call **585-327-5718**.

Continue to emphasize preventive care

MVP Health Care has enrolled many Medicare members who are patients in your practice. We are very fortunate in our service area to have so many good physicians who care for them. There are many physicians who have already begun transforming their practices into Patient Centered Medical Homes, implementing strategies to draw patients into their offices for preventive care services.

An annual visit is a covered benefit for our Medicare members at no cost to them. This exam will give you the opportunity to assess your patient, to keep them healthy and to identify any problems that may be starting to develop. It is an opportune time to talk about and put in place a plan of care (with input from your patient and his or her representative, when necessary) that identifies the services they should receive throughout the year.

The MVP Adult Preventive Care guidelines contain key USPSTF recommendations in an easy-to-follow table format. There is a special section for people ages 65 and older that includes additional tips, as the recommendations are tailored to this age group.

To access the guidelines:

- Go to **www.mvphealthcare.com/provider** and click on *Provider Quality Improvement Manual* under *Quality Programs*
- On the left-hand side of the page, click on *Preventive Health*
- Under *Clinical Guidelines* click *Adult Preventative Care Guidelines* (the guidelines are located on pages 2-4)

Member experience survey

Every year a survey is sent to a sample of MVP's Medicare Advantage Plan members to assess their satisfaction with the experience they encounter with health care. CMS added several questions to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey in 2012. The questions ask your patients about care coordination or assistance they receive from their doctor, including:

- Whether the doctor had medical records and other information about the enrollee's care
- Whether there was follow up with the patient to provide test results
- How quickly the enrollee received test results
- Whether the doctor spoke to the enrollee about prescription medicines
- Whether the enrollee received help managing care
- Whether the personal doctor is informed and up-to-date about specialist care

We value the excellent care and service that you provide to our members!

Member outreach calls

MVP has partnered with the Eliza Corporation to help us reach out to our Medicare membership using automated calls. This technology makes it possible to reach a much larger number of Medicare members. Your patients may receive a phone call from MVP to remind them to talk to their physician about issues such as bladder control, fall risk and physical activity. When they come to you about these types of concerns, you may want to discuss a plan of care for improving bladder control, reducing the risk of falling or what level of physical activity is right for their particular situation. There are some helpful tools in the *Provider Quality Improvement Manual* on our website. Visit **www.mvphealthcare.com/provider** and click on *Provider Quality Improvement Manual* under *Quality Programs*.

MVP's Medicare Star ratings: high-risk medications

The Center for Medicare & Medicaid Services (CMS) uses the Star rating system to evaluate Medicare Advantage health plans, as well as their networks of physicians and other health care providers. These Star ratings (from one to five stars, with more stars indicating higher quality) impact the reimbursement that plans receive from CMS to pay for member benefits and provider services.

One of the clinical quality indicators that CMS has included in the Medicare star rating program is high-risk medications (HRM). This is defined as the number of MVP Medicare Advantage beneficiaries 65 years

or older who received prescription fills for drugs with a high risk of serious side effects in the elderly.

MVP has created a high-risk medication report by prescriber for the most frequently prescribed medications that may cause harm in the elderly population. The report contains the member's name, medication prescribed, quantity dispensed, date of last fill and the pharmacy at which the prescription was filled. The goal of the report is to make the prescriber aware of these medications and offer alternatives that may be more clinically appropriate in the elderly population.

A list of medications that are considered high-risk by The Centers for Medicare & Medicaid Services (CMS), The American Geriatrics Society and the National Committee for Quality Assurance (NCQA) is provided below. Please note that the CMS HRM rate is calculated using a subset of these medications.

Medications considered "high-risk" for the elderly

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 your patients that are 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. The chart below can be used as a resource for you as it lists the most current medications considered to be high-risk, the reason for the risk and possible alternatives.

This list of high-risk medications is not intended as a substitute for clinical judgment.

Drug Classification	High-risk Medications	Reason for Risk	Alternatives
Alpha1-adrenergic antagonists	• doxazosin • prazosin • terazosin	High risk of orthostatic hypotension.	• Alternative benign prostatic hyperplasia (BPH) agents (tamsulosin, alfuzosin, finasteride, dutasteride). • Alternative agents for hypertension (diuretic, beta blocker, long-acting calcium channel blocker, angiotensin converting enzyme inhibitor, angiotensin receptor blocker).
Alpha-adrenergic agonists (centrally-acting)	• clonidine • guanfacine • methyldopa	High risk of Central Nervous System effects; may cause bradycardia and orthostatic hypotension.	Alternative agents for hypertension (diuretic, beta blocker, long-acting calcium channel blocker, angiotensin converting enzyme inhibitor, angiotensin receptor blocker).
Amphetamines	• amphetamine • benzphetamine • dexmethylphenidate • dextroamphetamine • diethylpropion • methamphetamine • methylphenidate • phendimetrazine • phentermine	Potential for dependence, hypertension, insomnia, appetite suppression and Central Nervous System stimulation.	No preferred agents exist; perform risk to benefit assessment.
Analgesics	• ketorolac • indomethacin	Increased risk of gastrointestinal bleeding.	Acetaminophen, short-term celecoxib. Moderate or severe pain: opioid analgesic combinations.
Anti-depressants (tricyclic)	• amitriptyline • clomipramine • doxepin • imipramine	Highly anticholinergic, sedating and risk of orthostatic hypotension.	Desipramine, nortriptyline or alternative class of antidepressants (selective serotonin reuptake inhibitor, serotonin-norepinephrine reuptake inhibitor).
Androgen/ anabolic steroids	• methyltestosterone	Potential for cardiac problems and contraindicated in men with prostate cancer.	Avoid unless indicated for moderate to severe hypogonadism.
Antiemetics	• trimethobenzamide	Risk for extrapyramidal adverse effects.	Dolasetron, granisetron, ondansetron, prochlorperazine (avoid in Parkinson's disease).
Antihistamines	• cyproheptadine • dexchlorheniramine • diphenhydramine • hydroxyzine • promethazine	Highly anticholinergic; increased risk of confusion, dry mouth, constipation and other anticholinergic effects.	Cetirizine, desloratadine, fexofenadine, loratadine, levocetirizine.
Antiparkinson agents	• benztropine • trihexyphenidyl	Highly anticholinergic; not recommended for prevention of extrapyramidal symptoms with antipsychotics.	No preferred agents exist; perform risk to benefit assessment.
Antipsychotics	• thioridazine	Increased risk of extrapyramidal, and anticholinergic adverse effects; increased risk of QT prolongation.	• Olanzapine*, quetiapine*, risperidone*, haloperidol *for use in patients with schizophrenia only; avoid use in behavioral problems of dementia unless all other non-pharmacological options have failed.
Antianxiety	• meprobamate	Highly sedating and a high risk of physical dependence.	Buspirone, paroxetine, escitalopram, duloxetine, venlafaxine ER.

Barbiturates	• butabarbital • butalbital • mephobarbital • pentobarbital • phenobarbital • secobarbital	High rate of physical dependence; risk of falls, confusion and cognitive impairment; risk of overdose at low dosages.	• No preferred barbiturates exist; perform risk to benefit assessment. • Alternative antiseizure agents if being used for seizures. • Consider short-term/intermittent use of ramelteon, zolpidem, zaleplon or eszopiclone if being used for insomnia.
Benzodiazepines	**short/intermediate-acting** • alprazolam • clonazepam • lorazepam • oxazepam • temazepam • triazolam **long-acting** • chlordiazepoxide • diazepam • flurazepam	Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents. Prolonged sedation and confusion leading to increased risk of falls, fractures and motor vehicle accidents.	• Buspirone, paroxetine, escitalopram, duloxetine, venlafaxine ER if being used for anxiety. • Consider short-term/intermittent use of ramelteon, zolpidem, zaleplon or eszopiclone if being used for insomnia. • Alternative antiseizure agents if being used for seizures. • Benzodiazepines are typically excluded from Medicare Part D benefits; enhanced plans will cover benzodiazepines for limited indications in 2013.
Calcium channel blockers	• nifedipine (short-acting)	Increased risk of hypotension, myocardial ischemia.	Long-acting nifedipine, other calcium channel blocker or alternative agents for hypertension (diuretic, beta blocker, angiotensin converting enzyme inhibitor, angiotensin receptor blocker).
Gastrointestinal antispasmodics	• atropine • clidinium-chlordiazepoxide • dicyclomine • hyoscamine • propantheline • scopolamine	Highly anticholinergic adverse effects, uncertain effectiveness.	No preferred agents exist; perform risk to benefit assessment.
Narcotics	• meperidine • pentazocine	CNS adverse effects including confusion and hallucinations; not effective at commonly prescribed dosages, neurotoxicity.	Fentanyl patch, hydrocodone, morphine, oxycodone.
Nonbarbiturate Hypnotics	• Chloral hydrate	Tolerance occurs within 10 days, and risks outweigh benefits in light of overdose which can occur with as little as 3 times the usual dose.	Short term use of nonbenzodiazepine hypnotics.
Nonbenzo-diazepine Hypnotics	• zolpidem • zaleplon • eszopiclone	Have similar adverse events to those of benzodiazepines in older adults (delirium, falls); minimal improvement in sleep latency and duration.	Avoid chronic use (greater than 90 days).
Oral estrogens	• conjugated estrogen • esterified estrogen • estropipate • estrogen/progesterone combination products	Evidence of carcinogenic potential (breast and endometrial cancer), lack of cardioprotective effect and cognitive protection in older women.	• No preferred oral agents exist; perform risk to benefit assessment. • Topical vaginal estrogen creams for symptom relief safe and effective.
Oral hypoglycemics	• chlorpropamide • glyburide	High risk of prolonged hypoglycemia in older adults.	Glipizide, glimepiride.
Prokinetics	• metoclopramide	Risk of extrapyramidal effects including tardive dyskinesia.	• No preferred agents exist for gastroparesis; perform risk to benefit assessment. • Alternative agents for nausea/vomiting or gastroesophageal reflux disease (GERD) if being used for these conditions.
Skeletal muscle relaxants	• carisoprodol • chlorzoxazone • cyclobenzaprine • metaxalone • methocarbamol • orphenadrine	Most muscle relaxants poorly tolerated by older adults because of anticholinergic adverse effects, sedation and increased risk of fractures.	Baclofen, tizanidine.
Thyroid hormones	• thyroid desiccated	Cardiac adverse effects.	Levothyroxine.
Urinary anti-infectives	• nitrofurantoin • nitrofurantoin macrocrystals • nitrofurantoin macrocrystal-monohydrate	Potential of pulmonary toxicity; safer alternatives available.	Sulfamethoxazole/trimethoprim, ciprofloxacin depending on infection.
Vasodilators	• dipyridamole (short-acting) • ergot mesyloid • isoxsuprine	Orthostatic hypotension; more effective alternatives available.	**Stroke prevention:** aspirin, Plavix, Aggrenox **Dementia:** donepezil, galantamine, rivastigmine, Exelon.