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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

Denise V. Gonick
President and CEO

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comments

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MVP® HEALTH CARE

www.mvphealthcare.com

HEALTH INSURANCE MARKETPLACE UPDATE

MVP Health Care® is excited to participate in the NY State of Health™ Marketplace. MVP understands this is a new experience for health care providers, members and health plans. We are committed to assisting as you navigate your way through the Marketplace with MVP members.

Authorizations

At this time, your authorizations for medical services will not transfer. Please re-submit for prior authorization after January 1, 2014 for existing MVP members who enroll in a Marketplace plan.

Eligibility and Benefits

How can you tell if patients are benefits-eligible? The cost share information is **not** listed on the new ID card. However, most plans are subject to a deductible. That's why it is very important to check member benefits by calling the Customer Care Center for Provider Services at **1-800-999-3920** or going online to check benefits. Log in to your account and click *Patient Eligibility*. *Member Benefits* and *Cost Share* can be found on the patient eligibility screen and in the benefits display tool.

Some important things to note regarding members in arrears:

- Federal guidelines dictate that members may be delinquent with their premiums and still considered eligible. Members will show as eligible if they are delinquent for less than 30 days and their claims will continue to be paid during the first 30 days of delinquency.
- Non- subsidized members delinquent with premium payments for more than 30 days will become ineligible immediately.
- Subsidized members will remain eligible for up to 90 days of non-premium payment at which time they will become ineligible. MVP will put claims in a hold status after the initial 30 days of delinquency until the 90-day mark. This period of time is longer than prompt pay laws and most of MVP's contracts allow for; however, it was determined that state law supersedes contractual agreements and prompt pay laws.
- If the member does not pay the premium by the 90-day mark, these claims will be denied as "member not eligible," at which time you may bill the member directly for the service. Federal guidelines state we must notify you of the possibility for denied claims when a member is in the second and third months of the grace period. Providers will receive a letter indicating a member is in the arrears for any claims received during the 31-90 day period.
- You can check a member's eligibility online as you do today. Marketplace members will show as eligible if they have paid their premiums. Subsidized members who are in the arrears after 30 days of non-payment will still show as eligible on the website; however, MVP is working on a solution to

Continued on page 2

show you that these members are in the arrears. After 90 days of non-premium payments the subsidized member will show as ineligible on MVP's website. Look for additional details on this topic in our upcoming March/April issue of *Healthy Practices*.

Formulary

This new formulary is for MVP plans (individual and small group) purchased both on and off the Marketplace. This formulary differs from the existing MVP Commercial formulary because select generics are in Tier 2, some non-formulary drugs require prior authorization and the preferred agents may be different in some therapeutic categories. To view the formulary, visit **www.mvphealthcare.com** and choose *Members* then *Manage Prescriptions*. Simply click on *Drug Coverage (Formularies)* to see the list of covered drugs.

- **Mail service** – There is no mail service benefit for members in a New York Individual plan. Coverage for these plans is limited to a 30-day supply of medication.
- **Prior Authorizations** – Active prior authorizations for prescription drugs **will** transfer for members who move to a Marketplace plan with the exception of Medicare and Medicaid.

Member ID cards

How can you determine the network that applies to each of your patients? The new ID cards will include the member's product name on the front. On the back, a Rate/Network Indicator will give you information for the member's plan so you can determine if you are a participating provider for that member.

To determine the MVP plans for which you are considered a participating provider, please use the *Find a Doctor* tool at **www.mvphealthcare.com**. Under the *Guest* tab, select a product and enter your information. You will need to do this for each individual product. If your name appears in the search results, you are a participating health care provider for members who are enrolled in that product.

If you have any questions about your participation status or about the Marketplace, please contact MVP's Customer Care Center for Provider Services at **1-800-999-3920**.

Additional Resources

MVP developed additional resources for you to assist when you see MVP Marketplace members. Visit **www.mvphealthcare.com/provider** and log in with your username and password then click *Online Resources*. There you will see a section for Marketplace. In addition, MVP created a *Quick Reference Guide* (QRG) for you to print off and keep at your desk to help navigate the Marketplace. This is located at **www.mvphealthcare.com/provider** under *Resources* where you will see a link to the *QRG* to print off.

If you have any questions on your participation status or about the Marketplace, please contact MVP's Customer Care Center for Provider Services at **1-800-999-3920**.

myMVP mobile app connects with members

MVP debuted its first mobile application ("app") in late summer 2013 to fit our members' busy lives. The **myMVP** mobile app gives members fast and free access to their health plan no matter where they go — and it just got better!

Now, in addition to providing instant access to MVP's *Find a Doctor* search tool, MVP Member ID card and Customer Care Center, **myMVP** allows members to check the status of their claims right from a smart-phone or other mobile device.

We are actively promoting the app and seeing a steady stream of downloads. **myMVP** is helping members connect with their health plan when and where they need it.

If you are a member of an MVP health plan, you can download the myMVP mobile app, too. Visit the App Store or Google Play to download the myMVP app onto your iPhone® or Android™ mobile device.

Note: MSG and data rates may apply. iPhone is a trademark of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc. Android is a trademark of Google Inc.

MOBILE APP ID CARD REMINDERS

- If an MVP patient shows you an ID card on a mobile device, please treat it the same as you would an actual "hard copy" ID card.
- Members can send you a copy of the ID card shown on their mobile device via email or fax if you require a copy of the card.
- The ID card that members can display and forward from their mobile device comes from the same system that MVP uses when we print and mail ID cards, so a member's electronic ID card looks the same as their hard copy ID card.

EFT/ERA coming soon

MVP is partnering with PaySpan® to offer you the health care industry's leading solution for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) in 2014. These services are FREE for your office to use and you'll be able to enroll online to start using them. We will communicate updates and details in upcoming issues of *Healthy Practices*, via *FastFax* and on our website.

PROFESSIONAL RELATIONS UPDATES

Code of ethics and business conduct summary

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

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

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

Reviewing the federal and state exclusion databases – MVP and its Government Programs contractors 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 and its contractors 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 – MVP prohibits employees from accepting or soliciting gifts of any kind from MVP's current or prospective vendors, suppliers, providers or customers that are designed to influence business decisions.

Detecting and preventing fraud, waste and abuse (FWA) – MVP has policies and processes in place to detect and prevent fraud, waste and abuse (FWA). 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.

Providing compliance training and fraud, waste and abuse (FWA) training – MVP's contractors that support its Medicare products are required to provide general compliance training and FWA training to their employees, subcontractors and downstream entities. The Centers for Medicare & Medicaid Services (CMS) provides a general compliance and FWA web-based 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 general compliance and 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 requirement.

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, **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.

Access and availability standards

The Department of Health (DOH) performs regular audits of MVP's network of health care providers. The purpose of the survey is to assess the compliance of PCPs and OB/GYNs participating in the NYS Medicaid Managed Care program with the medical appointment standards delineated in the Medicaid and Family Health Plus (FHP) contracts. The list of these access standards is available in Section 4 of the MVP *Provider Resource Manual* titled *Provider Responsibilities*.

Medicaid transportation carve-out

Effective January 1, 2014, emergency and non-emergency transportation for Medicaid Managed Care and non-emergency transportation for Family Health Plus members (ages 19 through 20) will be covered by regular Medicaid. This means that MVP will no longer cover medical transportation as part of plan benefits for MVP Option, as well as non-emergency transportation for MVP Option Family members ages 19 and 20 living in Monroe, Livingston and Ontario counties.

Please be advised that, for dates of service on and after January 1, 2014:

- Prior authorization requests and claims for non-emergency services should be directed to Medical Answering Services, LLC (MAS), the Non-Emergency Medical Transportation manager for these counties.
- Claims for emergency transportation for MVP Option members should be submitted to eMedNY.
- Claims for non-emergency transportation for MVP Option Family members should continue to be submitted to MVP.

Non-emergency services that were approved by MVP **prior** to January 1, 2014 for trips that occur **after** January 1, 2014 will be honored by MAS.

To arrange for medical transportation, contact MAS:

Monroe County	**1-866-932-7740**
Livingston County	**1-888-226-2219**
Ontario County	**1-855-733-9402**

MVP will continue to cover emergency transportation for MVP Option members in Genesee County. There are no changes to how non-emergency transportation is provided in Genesee County.

For questions, please contact MVP's Customer Care Center for Provider Services.

POPULATION HEALTH MANAGEMENT UPDATES

Depression during winter

Winter represents an increased risk for depression due to the shorter, darker days and decreased opportunities for physical activity. Helping patients recognize the symptoms of depression and educating them on the treatment opportunities may help mitigate the impact of seasonal depression.

To help you help your patients, ValueOptions® offers a PCP Hotline that provides "Curbside Consults" related to behavioral health issues. PCPs and specialists may contact the ValueOptions PCP and Peer Advisor's Scheduling Line for consultation at **1-877-241-5575**. Representatives are available Monday – Friday from 9 am to 6 pm Eastern Time.

Physical activity during winter

Winter is a great time to discuss physical activity with patients because many have committed to improved fitness but are limited by the weather. The American Heart Association recommends at least 30 minutes of moderate-intensity aerobic activity at least five days/week for a total of 150 minutes, or at least 25 minutes of vigorous aerobic activity at least three days/week for a total of 75 minutes; or a combination of the two AND moderate to high intensity muscle-strengthening activity at least two or more days/week for additional health benefits.

There are many opportunities for physical activities in the winter, both indoors and outdoors! Remind patients that they can visit a local shopping mall and walk in comfort. Many fitness clubs offer discounted rates at the beginning of the year and there are MVP plans that include reimbursement for fitness club membership fees. Outdoor activities include cross-country skiing and snow shoeing, as well as more traditional activities like Alpine skiing and winter hiking. Winter is beautiful and exercising outdoors on the milder days can improve fitness, while decreasing depression.

Please remember to talk with your older adult patients about being as active as possible. Not all of our Medicare Advantage Plan members leave the area in the winter months. Mentioning the SilverSneakers® Fitness Program may help get them out of the house and exercising safely while we wait for warmer weather! SilverSneakers is available to all MVP Medicare Advantage plan members.

um policyguide

JAN. 1, 2014

MVP Prior Authorization Process

This *UM Policy Guide* provides a quick reference of prior authorization requirements for MVP's fully-insured and self-insured plans. The guide should be used in coordination with the Prior Authorization Request Form (PARF). All services listed in this document require prior authorization by MVP.

MVP Fully-Insured Plans (HMO, POS, PPO & EPO)

If a procedure or service requires prior authorization:

- fax a completed PARF to **1-800-280-7346** or
- call the MVP Utilization Management Unit at **1-800-568-0458**.

MVP Self-Funded Plans (ASO-HMO, ASO-POS, ASO-PPO, ASO-EPO, ASO-Indemnity)

MVP Select Care (ASO) provides self-funded employer groups with customized health benefits packages. All MVP Select Care members have the employer's name and/or logo listed at the top of their ID cards. If your patient is an MVP Select Care (ASO) member:

- fax a completed PARF to **1-800-280-7346** or
- call the MVP Select Care UM Unit at **1-800-229-5851**.

Prescription Drugs

Self-administered medications covered under the prescription drug rider requiring prior authorization do not appear in this document. They are contained in the Prescription Drug formulary for commercial members and the Medicare Part D formulary for Medicare Part D members. The formularies are available online at **www.mvphealthcare.com**. See next page for more information about medications administered in the outpatient setting.

Behavioral Health Services

MVP Health Care has entrusted ValueOptions® to manage our members' behavioral health care (mental health and substance abuse) services. ValueOptions® is now administering behavioral health coverage for:

- All ASO (self-funded) plans
- All fully insured plans in New York and New Hampshire (HMO, POS, EPO, PPO, Indemnity, and Government Programs including Medicaid, Family Health Plus, Child Health Plus, and Medicare).

For all questions related to Behavioral Health Services please contact ValueOptions® at:

- **1-800-568-0458** and listen for the Behavioral Health Prompt for all members except Select Care (ASO) members
- **1-800-229-5851** and listen for the Behavioral Health Prompt for Select Care members
- You also may visit ValueOptions® online at **www.valueoptions.com**

Radiology, Scheduling and Radiation Therapy

MVP has delegated the UM review for all prospective review of Radiation Therapy, MRI/MRA, PET Scan, Nuclear Cardiology, and CT/CTA, and 3D rendering imaging to CareCore National, LLC in Bluffton, SC.

CareCore National (CCN) utilizes evidence-based guidelines and recommendations for imaging from national and international medical societies and evidence-based medicine research centers. For more information on CCN go to **www.mvphealthcare.com/provider,** then *Online Resources* and click on *Provider Resource Manual.* To obtain an authorization please submit requests online at **www.carecorenational.com** or call **1-800-568-0458** and follow the radiology prompts.

Chiropractic Services

MVP Health Care has delegated Landmark Healthcare, Inc. to manage our members' Chiropractic care. Landmark case managers, all of whom are licensed chiropractors, use nationally accepted clinical protocols as guidelines to make UM determinations. Contact Landmark's UM Department at **1-800-638-4557.**

Online Resources

Visit MVP online at **www.mvphealthcare.com** to print a *Prior Authorization Request Form* (PARF), review the *Physician Quality Improvement Manual and Tool Kit*, or access information and forms. Providers also may review the *Benefits Interpretation Manual* (BIM), MVP's medical policies. The BIM allows providers to determine if procedures require an authorization based on CPT code or the member's plan.

Samples of MVP Member ID Cards

Plan information, including images of ID cards, is online as part of MVP's *Provider Resource Manual* (PRM). Log in at **www.mvphealthcare.com/provider**, go to *Online Resources* and click on *Provider Resource Manual*. Select *MVP Plan Type Information* (Section 3) for details.

In-Office Procedure and Ambulatory Surgery Lists

Participating providers and their office staff can access the *In-Office Procedure and Ambulatory Surgery Lists* at **www.mvphealthcare.com**. Contact your professional relations representative if you prefer a paper copy.

Please note:

- The In-Office Procedure List details the CPT® codes that MVP requires to be performed in the physician's office. Claims submitted with a place of service other than the physician's office will be denied unless prior authorization is obtained.
- The Ambulatory Surgery List specifies the CPT®/HCPCS codes that MVP will reimburse when performed in the ambulatory surgery or in-office settings. Claims submitted with an inpatient setting will be denied unless prior authorization is obtained.
- All procedures are subject to the member's plan type and benefits.

PRIOR AUTHORIZATION REQUIREMENTS

All Plan Types

Procedures/Services Requiring Prior Authorization	For Prior Authorization Contact:
• **All Elective Inpatient Admissions** • Advanced Infertility (Available per contract, age requirement per NYS mandate) • Inpatient Rehabilitation • Skilled Nursing Facilities • Adult Day Care (MVP Option) • AIDS Adult Day Care (MVP Option)	Fax a completed PARF to **1-800-280-7346** or call UM at **1-800-568-0458**. For MVP Select Care (ASO) members, fax a completed PARF to **1-800-280-7346** or call the Select Care UM Dept. at **1-800-229-5851**.
• Transplants	Call **1-866-942-7966**
Medications (IV and most IM dosage forms) given in the office or outpatient setting that require prior authorization are listed here: • Commercial Formulary (HMO, POS, MVP Option Child, PPO, EPO and some ASO plans) • Option and Option Family Formulary • Medicare Part D Formulary (Preferred Gold, GoldAnywhere, GoldValue, USA Care and RxCare) • Health Insurance Marketplace Formulary (Individual and Small Group On and Off Marketplace plans) These formularies are located online at **www.mvphealthcare.com.**	For Commercial members, fax a completed form* to **1-800-376-6373**. *Forms can be found at **www.mvphealthcare.com/provider**

DME & Home Care Services (HMO, POS, ASO HMO, ASO POS, Healthy NY, MVP Option, MVP Option Child, MVP Option Family, MVP BasiCare PPO, Preferred Gold HMO, Gold Anywhere PPO, MVP Premier, MVP Secure, MVP Liberty, MVP VT Vitality, MVP Secure, Evolution Health, Preferred EPO, Preferred PPO, Alternet, Non Group Indemnity, HealthFirst)

Services	Procedures/Services/Treatments Needed	For Prior Authorization Contact:
Durable Medical Equipment	Durable Medical Equipment (DME) can be dispensed/billed from a physician's or podiatrist's office for stabilization and to prevent further injury, without prior authorization. This is to assure safe mobility and transportation home. The DME item must be billed with the office visit.	MVP DME Unit: **1-800-452-6966**; DME fax: **1-888-452-5947** Access DME Prior Authorization Code List and other DME information at: **www.mvphealthcare.com/provider/dme.html** or **tinyurl.com/yas3p5o**
Home Care Services	• Home Infusion • Nursing** • Occupational Therapy** • Physical Therapy** • Speech Therapy** • Terbutaline Therapy	MVP Home Care Unit: **1-800-777-4793, ext. 12587**

Outpatient Imaging Services and Radiation Therapy Management (HMO, POS, ASO HMO, ASO POS, Healthy NY, MVP Option, MVP Option Child, MVP Option Family, MVP BasiCare PPO, Preferred Gold HMO, Gold Anywhere PPO, MVP Premier, MVP Secure, MVP Liberty, MVP VT Vitality, MVP Secure, Evolution Health, Preferred EPO, Preferred PPO, Alternet, Non Group Indemnity, HealthFirst, IBM PPO, IBM EPO)

Plan Types	Services Requiring Prior Authorization	For Prior Authorization Contact:
Fully-Insured Plans	MRIs, MRAs, CT Scans, PET Scans, Nuclear Cardiology and Radiation Therapy	Care Core National has been delegated to perform imaging reviews for MVP and Radiation Therapy Management Requirement. Call **1-800-568-0458** and follow imaging prompts or submit requests online at **www.carecorenational.com**.
Self-Funded Plans	MRIs, MRAs, CT Scans, PET Scans and Nuclear Cardiology. *Please note that not all self insured plans require prior authorization of imaging.*	For those contracts with imaging authorization requirements and/or Radiation Therapy Management Requirements, call **1-800-568-0458** and follow imaging prompts or submit requests online at **www.carecorenational.com**.

If a physician sends a patient for a clinically urgent imaging study during non-business hours (i.e. evenings, weekends, holidays), the physician should call the MVP Imaging department at **1-800-568-0458** the next business day.

Additional Services (HMO, POS, ASO HMO, ASO POS, Healthy NY, MVP Option, MVP Option Child, MVP Option Family, MVP BasiCare PPO, Preferred Gold HMO, Gold Anywhere PPO, MVP Premier, MVP Secure, MVP Liberty, MVP VT Vitality, MVP Secure)

Procedures/Services Requiring Prior Authorization			For Prior Authorization Contact:
• Air Medical Transport/Air Ambulance (For non-emergency transport) • Bariatric Surgery • Blepharoplasty • Botox Injections (Office procedure only) • BRCA 1/BRCA 2 (Genetic testing for breast cancer) • Breast Implantation • Breast Reduction Surgery • Capsule Endoscopy • Cochlear Implants & Osseointegrated Devices • Consumer Directed Personal Assistant Program (MVP Option) • Continuous Glucose Monitoring • Cosmetic vs. Reconstructive Surgery • Court Ordered Services (coverage for MVP Care, FHP only) • Deep Brain Stimulation • Dental Services (Accidental Injury to Sound Teeth, Outpatient Services, Prophylactic) • DME/Prosthetics/Orthotics • Endovascular Treatment for AAA and Carotid Artery Disease • ESWT for Plantar Fasciitis (MVP Gold Only) • Gaucher's Disease Treatment • Gender Reassignment Surgery	• Genetic Testing/Chromosomal Studies • Hereditary Angioedema • Hip Resurfacing • Hip Surgery for FAI • Hyperbaric Oxygen Therapy • Hyperhidrosis Treatment • Immunoglobulin Therapy • Implantable Cardiac Defibrillators • IMRT • Infertility (Advanced and/or Secondary), available with Rider - Including drugs (e.g., Follotropins, Menotropins) - GIFT/ZIFT are not covered • Interstim (Sacral Nerve Stimulator) • Left Ventricular Assist Device • Lumbar Laminectomy (Discectomy)* • MSLT – Multiple Sleep Latency Testing • Neuropsychological Testing • New Technology • Oncotype Diagnostic Testing • Oral Surgery/Orthognathic Surgery • Organ Donor • Orphan Drugs • Panniculectomy/Abdominoplasty • Pectus Excavatum	• Penile Implants • Percutaneous Vertebroplasty/Kyphoplasty • Personal Care Service (MVP Option) • Photodynamic Therapy (Malignant conditions) • Private Duty Nursing (Coverage for MVP Care, FHP, CHP only) • Rhinoplasty • Rhizotomy/Radiofrequency Ablation • Sclerotherapy • Septoplasty* • Skin Endpoint Titration • Sleep Studies (Facility based) • Speech Generating Devices • Speech Therapy – Selected Contracts • Spinal Fusion - Lumbosacral • Spinal Stimulator • Synagis (Injectable for RSV) • Thoracic Electrical Bioimpedance • TMD/TMJ • Treatment of Obstructive Sleep Apnea (Policies A & B) • UPPP Surgery • Virtual Colonoscopy • VNUS/EVLT • Wound Vacs	Fax a completed PARF to **1-800-280-7346** or call UM at **1-800-568-0458**. For MVP Select Care (ASO) members: • Call the Select Care Member Services Dept. at **1-800-229-5851** to confirm member benefits • Fax a completed PARF to **1-800-280-7346** or call the Select Care UM Dept. at **1-800-229-5851** *Some employer groups offer more than one MVP plan, so be sure to review the member's ID card.*

Evolution Health, Preferred EPO, Preferred PPO, Alternet, Non Group Indemnity, HealthFirst

Procedures/Services Requiring Prior Authorization			For Prior Authorization Contact:
• **Elective Inpatient Admissions** • Advanced Infertility (Available per contract, age requirement per NYS mandate) • Air Transport • Bariatric Surgery • Blepharoplasty • Breast Implantation • Breast Reduction • Cochlear Implant • Continuous Glucose Monitoring • Endovascular Treatment for AAA and Carotid Artery Disease • Gender Reassignment Surgery	• Genetic Testing† • Hip Resurfacing • Hip Surgery for FAI • Implantable Cardiac Defibrillators • Left Ventricular Assist Device • Liposuction • Lumbar Laminectomy (Discectomy)* • Oncotype Testing† • Orthognathic Surgery • Panniculectomy • Pectus Excavatum • Penile Implants	• Percutaneous Vertebroplasty/Kyphoplasty • Rhinoplasty • Rhizotomy • Sacral Nerve Stimulator • Sclerotherapy • Septoplasty* • Sleep Studies (Facility based) • Spinal Fusion – Lumbosacral* • Spinal Stimulator • TMD/TMJ • UPPP Surgery • Varicose Vein Treatment	Fax a completed PARF to **1-800-280-7346** or call UM at **1-800-568-0458**. For MVP Select Care (ASO) members, fax a completed PARF to **1-800-280-7346** or call the Select Care UM Dept. at **1-800-229-5851**.

IBM Plan Types

Procedures/Services Requiring Prior Authorization		For Prior Authorization Contact:
• **Elective Inpatient Admissions** • Bariatric Surgery • Hospice • Organ Transplants	• Rehabilitation Facilities • Skilled Home Care • Skilled Nursing Care • Speech/Occupational/Physical Therapy (More than 40 visits per year)	Call the Select Care UM Dept. at **1-800-229-5851**.

*Denotes when InterQual® criteria is used for the procedure.

**HHA agencies to refer to their contract or the *Provider Resource Manual* (PRM).

Criteria for these procedures may be found in MVP's *Medical Policy (Benefit Interpretation Manual)* at **www.mvphealthcare.com.**

†PPO Select; Preferred EPO/PPO and TriVantage

Comparison of Plan Types

MVP FULLY INSURED PLANS

Plan Type	PCP	Referral Required	Prior Auth. Required	Formulary	Reduction of Benefits for Not Notifying MVP of Inpatient Admission	Access to a National Network	Out of Network Benefits
MVP HMO	Yes	No	Yes	Yes	No	No	No
MVP POS	Yes	No	Yes	Yes	For Out-of-Network Care Only	No	Yes
MVP Basix	Yes	No	Yes	Yes	For Out-of-Network Care Only	No	No
MVP Preferred PPO	No	No	Yes	Yes	For Out-of-Network Care Only	Yes	Yes
Preferred Gold HMO-POS GoldValue HMO-POS	Yes	No	Yes	Yes	No	No	Yes
GoldAnywhere PPO	No	No	Yes	Yes	No	No	Yes
BasiCare PPO	No	No	Yes	Yes	No	No	Yes
MVP Preferred EPO	No	No	Yes	Yes	No	Yes	No
MVP Healthy NY†	Yes	No	Yes	Yes	No	No	No
MVP Option	Yes	Yes*	Yes	Yes	No	No	No
MVP Option Child	Yes	Yes*	Yes	Yes	No	No	No
MVP Option Family	Yes	Yes*	Yes	Yes	No	No	No
USA Care PPO	No	No	No	Yes	No	No	Yes
MVP Preferred EPO – BridgeWell	No	No	Yes	Yes	No	Yes	No
HQNet	No	No	Yes	Yes	No	No	No
MVP Evolution Health EPO	No	No	Yes	Yes	No	Yes	No
MVP Premier	Yes	No	Yes	Yes	No	No	No
MVP Premier Plus	Yes	No	Yes	Yes	No	No	No
MVP Liberty	No	No	Yes	Yes	No	Yes	No
MVP Secure	Yes	No	Yes	Yes	No	No	No

†For eligible small employer groups only.

*For MVP Option, MVP Option Child and MVP Option Family, notification of referral is required for the following services: Dermatology, Maternity Admission, Oral Surgery and Plastic Surgery. Notification must be obtained within 14 days of the date of service. To obtain notification, call **1-800-684-9286**.

MVP SELF FUNDED (SELECT CARE ASO) PLANS

Plan Type	PCP	Referral Required	Prior Auth. Required	Formulary	Reduction of Benefits for Not Notifying MVP of Inpatient Admission†	Access to a National Network	Out of Network Benefits
ASO-HMO	Yes	No	Yes	Varies by Employer Group	No	No	No
ASO-POS	Yes	No	Varies by Employer Group	Varies by Employer Group	For Out-of-Network Care Only	No	Yes
ASO-PPO	No	No	Varies by Employer Group	Varies by Employer Group	No	Yes	Yes
ASO-Indemnity	No	No	Varies by Employer Group	Varies by Employer Group	No	N/A	Yes
ASO-EPO	No	No	Varies by Employer Group	Varies by Employer Group	No	Yes	No

Prior authorization requirements can be confirmed with MVP's Utilization Management Department at **1-800-568-0458**. For MVP Select Care (ASO) members, please call **1-800-229-5851**. Full benefits are not listed above.

†Reduction of benefits for the member also applies for same day surgery.

MVP has attempted to capture all prior authorization requirements for each plan type in this document. However, benefit plans, as with member eligibility, are subject to change and do, frequently. If you have questions concerning a member's benefit coverage or about services/procedures not on this document, call our Member Services Unit at **1-888-687-6277** or **1-800-229-5851** for MVP Select Care (ASO) members.

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CARING FOR OLDER ADULTS

Talk with your patients

MVP wants our Medicare Advantage Plan members, your patients, to 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 of our newsletter, to educate and assist them. We encourage them to talk with you about:

- Blood pressure testing, monitoring and control
- Body Mass Index or 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), dilated eye exam by an eye care provider
- Glaucoma testing as recommended
- Testing and treatment of osteoporosis

It is also important for them to talk to you about difficult or sensitive issues such as:

- 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 following through on your recommendations.

CLAIMS UPDATES

ICD-10 rules

As you work through testing and training for ICD-10, which is required on October 1, 2014 by the Centers for Medicare & Medicaid Services (CMS), please be sure to follow these ten important rules.

1. **The documentation must be legible** – If a record cannot be read or interpreted, it is of little value. However, with a little help, the coder or auditor should be able to decipher the provider's documentation. Dictated or computer generated records can be a great benefit in this area.
2. **Every record must contain basic data** – These include patient name, patient birth date, the encounter date and time, vital signs, allergies and the location of the service. Upon completion, every record must be signed by the provider, whose printed name should also be a part of the record.
3. **The record must be organized** – Encounters should follow the format of: chief complaint, history, exam and diagnosis/plan. The history (HPI) must be broken down into the review of systems (ROS) and the past, family and social history (PFSH).
4. **Documentation must match the billed services** – Every billed service and its corresponding diagnosis code must be clearly documented in the medical record. For example, if you are relying upon the evaluation of two stable medical problems to support a level four encounter, the pertinent history and exam for each of the problems must be found in the record.
5. **Medical decision making (MDM) must match service level** – MDM is the overriding determinant of the level of service and a billed service level should never exceed the MDM reflected in the documentation.
6. **Addendums or alterations must be properly identified** – Ideally, an encounter should be fully and completely documented within eight hours, and certainly no more than 24 hours after the service. Additions to a completed record should be clearly labeled as such and include the date, time and reason for the addendum. When making a late addendum, it is preferable to place it on a separate page from the original document to avoid the impression that the author was attempting to alter the original record.
7. **Do not clone medical records** – Cloning medical records refers to the abusive use of boilerplate data, or carrying forward large portions of a patient's prior record to the current encounter.
8. **Do not abuse modifier 25** – Modifier 25 is proper only when a separately identifiable E/M service is performed, in addition to another procedure or service.
9. **The necessity of ancillary testing must be clear** – When testing or procedures are part of the encounter, the reason and necessity for these items must be clearly documented or intuitively obvious to medical personnel. Although "rule out" diagnoses are not valid to submit for billing purposes, they can be used in the text of the record to explain the need for testing.

10. **Note face-to-face time for time-based encounters** – When time-based billing is used, a simple statement that over 50 percent of time was spent in consultation with the patient is required, as well as the total number of minutes spent "face-to-face" with the patient. The subject matter of the counseling should also be recorded in adequate detail to support the amount of counseling time.

Source: AAPC Physician Services

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the November 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, visit *Online Resources* and click *BIM* under *Policies*. The *Current Updates* page of the *BIM* lists all medical policies 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 Feb. 1, 2014

Air Medical Transport

Language has been added that coverage is not available for transport from a hospital when the patient and/or patient's family prefer a specific hospital or physician. Air Medical Transport is not covered for MVP Option Child.

Cell-free Fetal DNA Pre-natal Testing

This is a new medical policy. The policy addresses non-invasive prenatal screening for fetal chromosomal aneuploidies. The testing criteria follow the American College of Obstetricians and Gynecologists (ACOG) opinion on non-invasive prenatal testing for fetal aneuploidy. Non-invasive prenatal screening testing for fetal aneuploidy is subject to retrospective review.

Cochlear Implants & Osseointegrated Devices

Criteria for Transcutaneous Bone Anchored Hearing Aid utilizing a headband or soft band as an alternative to an implantable BAHA have been added to the medical policy. Transcutaneous Bone Anchored Hearing Aid utilizing a headband or soft band requires prior authorization. Degrees of hearing loss have been added to the medical policy.

Experimental or Investigational Procedures

There are no changes to the medical policy.

Neuropsychological Testing

The statement "The test results must be interpreted by a doctorate level Psychologist" has been removed from the medical policy.

Private Duty Nursing

Criteria are based on Medicaid. Coverage may be limited by individual contract benefits. There have been no criteria changes to the medical policy.

Prosthetic Devices (Eye & Facial)

Criteria have been added for Scleral Shells to the medical policy. Scleral Shells require prior authorization.

Psychological Testing

There have been no changes to the medical policy.

List of Medical Policies recommended for approval without changes in November 2013:

- Durable Medical Equipment
- Hyperbaric Oxygen Therapy (HBO)
- Injection Procedures for the Management of Chronic Spinal Pain
- Prosthetic Devices (Upper & Lower Limb)

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

Policy updates effective January 1, 2014

Antineoplastic Enzyme Inhibitors
- Stivarga added to the policy

Constipation and IBS
- New indication for Amitiza added
- Linzess added to the policy

Crohn's Disease and Ulcerative Colitis
- Simponi added to the policy
- Remicade covered under the pharmacy benefit on the Marketplace Formulary

Government Programs OTC Coverage
- Policy updated to reflect Medicaid fee-for-service (FFS) coverage. A link to the FFS

Juxtapid and Kynamro (NEW)
- Established criteria for the treatment of homozygous familial hypercholesterolemia

Multiple Myeloma (NEW)
- Policy includes criteria for the coverage for Revlimid, Kyprolis and Pomalyst. Criteria is based on NCCN guidelines and drug prescribing information.

Proton Pump Inhibitors
- Language added to reflect new prior authorization requirement for all multi-source brand PPIs

Quantity Limits
- Temodar removed from the policy

Zorbtive and Gattex
- Previously named Zorbtive policy
- Gattex added with criteria including but not limited to 18 years of age and older, parenteral nutrition support for at least 12 consecutive months and a colonoscopy within six months of starting therapy

The following policies were reviewed and approved without any changes to criteria:
- Cialis for BPH
- Patient Medication Safety

Formulary updates for Commercial, Option and Marketplace formularies

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

Drug Name	Indication
Belviq	Weight Loss
Breo Ellipta	COPD
Gilotrif+	NSCLC
Liptruzet	Cholestero1
Mekinist+	Melanoma
Nymalize	SAH
Prolenza	Ocular Inflammation
Signifor	Cushing's Disease
Simbrinza	Glaucoma
Simponi Aria*	Rheumatoid Arthritis
Suclear	Colon Cleanser
Tafinlar+	Melanoma
Tivicay	HIV-1

Drugs added to Formulary (Tier 1)

acamprosate	lidocaine patch
adefovir	niacin extended-release
cevimeline	riluzole
choline fenofibric acid	repaglinide
temozolomide	

Drugs moved from Tier 2 (formulary) to Tier 3 (non-formulary)

Lidoderm	Niaspan

*Medical drug
+Must be obtained from Accredo Specialty Pharmacy

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