HEALTHY PRACTICES™

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New York/MVMA

IN THIS ISSUE

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We welcome your comments.

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PROFESSIONAL RELATIONS UPDATE

Reminder! ICD-10 is Coming!

Effective October 1, 2015, federal guidelines will go into effect requiring all electronic and paper claims to be submitted with ICD-10 diagnosis codes. Claims received with a date of service on or after October 1, 2015, which do not have an ICD-10 diagnosis, will be rejected. MVP has partnered directly with provider offices, hospitals, and clearinghouses to perform testing of ICD-10 claims. The testing for these claims will be completed by July 31, 2015. MVP is no longer accepting new ICD-10 test partners.

MVP would also like to announce our new ICD-10 email address, **CodingICD10@mvphealthcare.com**, which you can use for all your general ICD-10 questions. We have also implemented a webpage devoted to ICD-10 information for providers; visit **www.mvphealthcare.com**, select *Providers*, then *ICD-10 Updates and FAQs* under the ICD-10 heading. If you are interested in having a trainer come to your office, please contact Shannon Chase at **518-386-7502** or **schase@mvphealthcare.com**.

Helping Adolescent Patients Find an Adult Care Provider

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

MVP's online provider directory enables members to search for and choose an adult provider by several preferences such as location, board certification, gender, or language spoken. Go to **www.mvphealthcare.com** and select *Find a Doctor*, then *Search By Provider*.

The MVP Customer Care Center is available to assist older adolescent members with transitioning from a pediatrician and/or pediatric specialists to an adult provider when they wish to make the change. Members can reach the Customer Care Center by calling the phone number on the back of their MVP Member ID card.

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

Financial Incentives Relating to Utilization Management

It is the policy of all of the operating subsidiaries of MVP Health Care, Inc. (MVP) to facilitate the delivery of appropriate health care to our members and to monitor the impact of the plan's Utilization Management Program

to ensure appropriate use of services. MVP's Utilization Management Program does not provide financial incentives to employees, providers, or practitioners who make utilization management decisions that would encourage carriers to provide care and services.

MVP's utilization management decisions are based only on appropriateness of care and the benefits provisions of the member's coverage. MVP does not specifically reward practitioners, providers, or staff, including Medical Directors and Utilization Management staff, for issuing denials of requested care. MVP does not offer financial incentives, such as annual salary reviews and/or incentive payments to encourage inappropriate utilization.

In Office Procedure List Reminder

MVP previously communicated through *FastFax* a change that is effective July 1, 2015 regarding the In Office Procedure List.

The In-Office Procedure List is comprised of procedures that are limited to the physician's office place of service (POS). Any procedures performed outside of the physician office at POS 22 or 24 will be denied if there is no Prior Authorization on file. All lines of business require prior authorization for site of service.

MVP has changed how we deny these procedures when no authorization is on file. Review of the procedures on this list is based on contractual agreements to comply with MVP policies. Since this is a POS review, there are no appeal rights.

Please refer to the Place of Service Payment Policy, Split Billing Payment Policy in Section 15, Payment Policies, of the *Provider Resource Manual* for details on billing correct place of service.

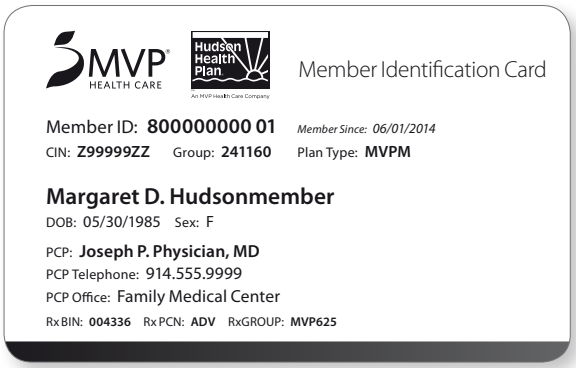
The *In-Office Procedure List* and the *Provider Resource Manual* are available on **www.mvphealthcare.com** by selecting *Providers*, then *Log In* using your MVP username and password. Once logged in, select the gray box to access your profile and choose *Online Resources* on the left.

Provider Medicaid Participation

As previously communicated, MVP Health Care has integrated with Hudson Health Plan for the Medicaid and Child Health Plus products in the Mid Hudson Valley. Although this integration has occurred from a system perspective, Hudson Health Plan has retained its membership and provider network, pending full member migration to MVP scheduled for January 1, 2016.

What Does This Mean for Providers Until January 1, 2016?

If a provider is participating with MVP for the Medicaid and Child Health Plus products, they can only see members who are enrolled in the MVP network. The MVP provider contract does not extend to the Hudson Health Plan Medicaid or Child Health Plus products. If a member presents with a member ID card that has both an MVP and Hudson Health Plan logo (as seen below) on it, they are a Hudson Health Plan member and should not be seen by a provider who is participating with MVP only.



If a provider that is participating with MVP provides services to a Hudson Health Plan member, the claim will be denied as non-participating and the Medicaid or Child Health Plus member will be held harmless.

Provider Demographic Changes

MVP makes every effort to ensure a provider's demographic information is accurate in our systems.

If you or your practice have changes in demographic and/or participation status, it is important to promptly notify MVP.

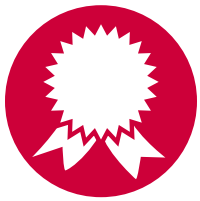
Examples of status changes are:

- No longer accepting patients
- Address, telephone number, or tax ID number changes

To report demographic changes to MVP, please complete a Provider Demographic Change form. The forms can be downloaded by visiting **www.mvphealthcare.com** and selecting *Provider* and then the appropriate form under *Provider Demographic Change Forms*. Please fax the completed demographic change form on letterhead to **518-836-3278**, or email your demographic changes to **professionalrelations@mvphealthcare.com**. For more information, see section 4 of the *Provider Resource Manual*.

QUALITY UPDATES

HEDIS/QARR Measure Spotlight



HEDIS (Healthcare Effectiveness Data & Information Set) is a nationally recognized set of health care quality measures that contribute significantly to MVP's NCQA (National Committee for Quality Assurance) accreditation score. MVP collects HEDIS data from claims information and by chart review in many offices across our service area. MVP monitors its performance in these measures on an ongoing basis and submits results to NCQA annually. The state and federal government also monitor the HEDIS measure results to assess the quality of care that the members of health plans receive from their contracted physicians. The CMS Star Rating Program and state QARR (Quality Assurance Reporting Requirements) programs are two examples.

Results are also produced at the practice level for use in Clinical Reporting; allowing providers to see how they compare in relation to the health plan averages. Below is information on select HEDIS measures that relate to Behavioral Health. If you have questions on compliance with any HEDIS measure, please contact Michael Farina at **518-388-2463** or **mfarina@mvphealthcare.com**.

IET–Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Compliance is achieved when members 13 years of age and older with a NEW episode of alcohol or other drug (AOD) dependence receive the following:

1. **Initiation of AOD Treatment**–within 14 days of the diagnosis, treatment must be initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.
2. **Engagement of AOD Treatment**–within 30 days after the date of initiation encounter, the member must have two or more additional services with a diagnosis of AOD.

AMM–Antidepressant Medication Management

This measure focuses on members with a diagnosis of Major Depression who were treated with an antidepressant medication (ages 18 and up). Two medication adherence rates are reported:

1. **Effective Acute Phase Treatment**–members must remain on an antidepressant medication for at least 84 days (12 weeks).
2. **Effective Continuation Phase Treatment**–members must remain on an antidepressant medication for at least 180 days (6 months).

ADHD-Follow-Up Care for Children Prescribed ADHD Medication

This measure focuses on children between the ages of 6 and 12 who were newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication. Two rates for follow-up visits are reported:

1. **Initiation Phase**–children must have one follow-up visit with practitioner with prescribing authority within 30 days from when the medication was dispensed.
2. **Continuation and Maintenance Phase**–in addition to the initial visit within 30 days, children must have two additional visits within nine months after the Initiation Phase has ended.

We understand the challenges providers face to help educate patients and influence behavior change; especially when dealing with mental illness/substance abuse. We have various resources available to support your work—some of these are described below.

Primary Care Quality Reports

MVP produces several reports for physicians:

- **The Accountable Care Metrics (ACM) Report** currently includes the AMM and ADHD measures as well as the IET measure (Medicare population only). This report depicts the practices rate for each measure, compared to the health plan mean and goal. Results are taken into consideration in MVP's Pay for Performance (P4P) program.
- **The Gaps in Care Reports** help providers identify members in need of certain visits/screenings. These reports are in Microsoft Excel and PDF format so that the practice can manipulate the patient lists to best suit their needs. The reports are delivered monthly via secure email.

Throughout the year, Clinical Reporting Coordinators visit practices to review their results and provide them with suggestions and tools to help improve their performance. If you have any questions on these reports or would like to schedule a visit, please contact Mike Farina at **518-388-2463** or **mfarina@mvphealthcare.com**.

Toll-Free Behavioral Health Consultation Line for Providers

For our New York practitioners, ValueOptions® offers a toll-free Behavioral Health Consultation Line staffed by Board Certified Psychiatrists. These psychiatrists are available for telephonic consultation regarding all aspects of mental health and substance abuse treatment for children and adults, including appropriate use of psychotropic medications. Primary care physicians as well as specialists may contact the ValueOptions® PCP Line for consultation at **1-877-241-5575**, Monday–Friday, 9 am–5 pm Eastern Time.

Clinical Guidelines and Tools

MVP has adopted clinical practice guidelines that address the behavioral health HEDIS measures. They can be found in the Behavioral Health section of the *Provider Quality Improvement Manual*. Visit **www.mvphealthcare.com** and select *Providers*, then *Provider Quality Improvement Manual*, and then *Behavioral Health*. Also located here are many tools providers can use for screening and treatment of these conditions.

Educational Support for Members–ADHD Program

ValueOptions® has an ADHD program that members living in New York can access online at **www.valueoptions.com** under *Members*, select *Member Tips and Resources* in the Spotlight section, and then *ADHD Treatment Support Program* under Attention Deficit/Hyperactivity Disorder. Members can complete an Online ADHD Screening Tool and receive a call back from ValueOptions® if the child's results indicate that further evaluation may be needed. Additionally, members can receive a free workbook, *Attention Deficit Hyperactivity/Disorder—Your Child and You*.

MVP also makes phone calls to parents of children who have recently started on a medication for ADHD to ensure they have an appointment scheduled within 30 days. MVP may contact the provider's office to verify the member has an appointment scheduled within the recommended time frame.

Educational Support for Members–Depression Program

ValueOptions® also has a Depression Identification and Management Program. The program targets those members who have possible depression based on the PHQ-9 screening tool, members who have been recently diagnosed, and/or members who are currently receiving treatment for depressive disorders. Members can also self-refer to the program.

The program assists members in accessing care, provides a timely assessment by a trained clinician, educates members on treatment options, and provides educational materials. All members in the program are also offered a referral to a behavioral health specialist. Those members with more complex needs are considered for placement in the Intensive Case Management (ICM) program.

To refer a member to this program, please call ValueOptions® at **1-855-300-7959**.

Coordination of Care With Behavioral Health Providers

Individuals who are depressed or have other mental health/substance abuse issues often have trouble following through with recommendations. If you have referred a patient to a behavioral health provider, it is important that you follow-up to ensure the appointment was made in a timely manner and the individual attended it.

MVP strongly encourages Behavioral Health specialists to communicate with the members primary care physician. This allows both health care providers to have a complete overview of the member's health issues and concerns, in addition to coordinating any medications the member may receive. Communication and coordination among providers is essential to help reduce medical errors and improve quality, safety, and continuity of care.

If you have any questions or would like assistance, please call PrimariLink at **1-800-320-5895**.

CARING FOR OLDER ADULTS

A New Program for Medicare Advantage Plan Nursing Home Residents

MVP is offering Optum™ CarePlus to Medicare Advantage plan members who are residents in select nursing homes. Through CarePlus, a nurse practitioner or physician assistant follows a treat-in-place care model, working with members as health care advocates and offering an extra layer of specialized care.

A nurse practitioner or physician assistant meets with the member one-on-one to help manage their overall health, any chronic conditions, prescription medications, or other concerns. Visits are conducted as needed—monthly, weekly, or daily—with additional availability 24/7 by phone. Clinicians collaborate with the primary care physician and others on the health care team to coordinate multiple treatments, health maintenance, and preventive

care services. The nurse practitioner or physician assistant is also the main point of contact for family members about their loved one's ongoing care.

MVP's goal is to keep members healthier by taking care of their health needs where they live, identifying changes in health conditions before they become serious, avoiding emergency room visits and hospital admissions, and providing extra support for their overall care.

MVP Medicare Advantage plan members must sign-up to participate in CarePlus. Members who qualify received information about the program in June. There is no extra cost to participate in CarePlus as an MVP Medicare Advantage plan member; participation does not affect MVP membership.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the June meeting. Some of the medical policies may reflect new technology while others clarify existing benefits. *Healthy Practices* and/or *FastFax* will continue to inform your office about new and updated medical policies. MVP encourages your office to look at all of the revisions and updates on a regular basis in the *Benefit Interpretation Manual (BIM)* located on **www.mvphealthcare.com**. To access the BIM, *Log In* to your account, select *Online Resources* and then *BIM* under *Policies*. The *Current Updates* page of the BIM lists all medical policy updates. If you have questions regarding the medical policies or wish to obtain a paper copy of a policy, contact your Professional Relations Representative.

Medical Policy Updates Effective August 1, 2015

Benign Skin Lesions: Language in the Documentation Requirements section regarding the decision to submit a specimen for pathological interpretation will be independent of the decision to remove or not to remove the lesion has been removed. Also language regarding the statement of an "irritated skin lesion" has been removed as well. Indications and criteria for Total Body Photography have been added to the policy.

BRCA Testing: The BRCA Testing policy follows the NCCN guidelines for BRCA testing. There is an addition to criteria for an individual with personal history of pancreatic cancer or aggressive prostate cancer (Gleason score ≥7) at any age with ≥ two close blood relatives. For pancreatic cancer, if Ashkenazi Jewish ancestry, only one additional affected relative is needed was added. BRCA testing as a component of multi-gene panels (e.g. my Risk) is considered investigational.

Breast Pumps: There are no changes to the medical policy criteria.

Chiropractic Care: The following language was added to the policy, "Chiropractic treatments to extraspinal regions is not covered unless regulatory guidelines require coverage."

Continuous Passive Motion Devices: Revision of total knee arthroplasty was added as an indication.

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

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

Evaluation of New Technology, Procedures, Behavioral Health Services, and Programs: Language was added to the policy to state that an MVP Review Application Form is available to assist the requestor. The form may be completed and returned to MVP. Previously, the policy stated that the MVP Application Form **must** be completed and submitted to MVP.

Fish Testing for Bladder Cancer Screening: There are no changes to the medical policy criteria.

Gender Reassignment Surgery: A Medicaid Variation was added to the policy. Gender reassignment surgery is now covered for MVP/ Hudson Health Plan Medicaid products when policy indications and criteria are met.

Medical Policy Development, Implementation Review Process: There are no changes to the policy.

Temporomandibular Joint Dysfunction (TMJ)-NY: There are no changes to the medical policy criteria.

Transcatheter Aortic Valve Replacement: The policy was updated to state that transaortic valve replacement (TAVR) must be performed at a facility listed in the Medicare approved registry. There is a link to the Medicare approved registry.

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

Vertebroplasty/Kyphoplasty: Vertebroplasty/ Kyphoplasty indications and criteria now follow Medicare criteria for all products.

Vision Therapy (Orthoptics, Eye Exercises): The policy was updated to include oculomotor exercises for convergence insufficiency. Vision therapy is considered investigational for correction of learning disabilities.

Medical Policies for Approval Without Changes in May and June 2015

- Adult Day Care Services
- Artificial Heart
- Biofeedback Therapy
- Cold Therapy Devices
- Emergency Department Services
- Experimental or Investigational Services
- Mechanical Stretching Devices
- Monitored Anesthesia Care
- Needle-free Insulin Injectors
- Phototherapy, Photochemotherapy, Excimer Laser Therapy
- Prosthetic Devices (Upper and Lower Limb)
- Skin Endpoint Titration
- Tear Osmolarity
- Transplants
- Vitiligo

PHARMACY UPDATES

Suboxone

Suboxone (all strengths) has a quantity limit of 90 sublingual films per 30 days for Medicaid members. Please note that Suboxone is available in the following strengths: 2mg/0.5mg, 4mg/1mg, 8mg/2mg, and 12mg/3mg. Dose increases can be achieved by utilizing the higher strengths of Suboxone versus increasing the frequency of the lower strengths, thereby avoiding the need to obtain prior authorization for exceeding the quantity limit.

Pharmacy Updates Effective June 1, 2015

Psoriasis Drug Therapy

- Stelara prefilled syringes added to policy requiring PA under pharmacy benefit.
- Provider administered Stelara will require documentation that the member is unable to self-administer.

Mepron (atovaquone)

- Approval for brand name Mepron will require intolerance to generic atovaquone suspension.

Migraine Agents

- Language added to clarify that all brand name products with generic equivalents will require prior authorization.

Doryx/Oracea(doxycycline)

- Language added to clarify generic delayed released doxycycline products will require prior authorization.
- Criteria clarified that failure/intolerance of doxycycline IR will be required.

Policies Reviewed and Approved Without Any Changes

- Cosmetic Drug Agents
- Copayment Adjustment for Medical Necessity
- Medicare Part B vs. Part D Determination

Formulary Updates for Commercial, Medicaid, and Marketplace Formularies

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

Drug Name	Indication
Lynparza	Ovarian cancer
Rytary	Parkinson's Disease
Cosentyx	Psoriasis
Evotaz	HIV
Duopa	Parkinson's Disease
Movantil	Opioid-induced constipation
Ibrance	Breast cancer
Arnuity Ellipta	Asthma
Incruse Ellipta	COPD
Savaysa	DVT and PE
Opdivo	Melanoma
Hysingla ER	Pain
Evekeo	Narcolepsy, ADHD
Glyxambi	Diabetes
Sotylize	Ventricular arrhythmia
Signifor LAR	Acromegaly
Lenvima	Thyroid cancer
Natesto	Hypogonadism
Farydak	Multiple myeloma
Novoeight	Prevention of bleeding
Toujeo	Diabetes

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

Colchicine caps
Dexmethylphenidate SR 10mg
Lamotrigine ODT
methylphenidate chews
Naproxen sodium SR
Pramipexole SR
Trandolopril-verapamil

Drugs Removed from Prior Authorization

Beleodaq
Dalvance
Evzio (Quantity limit of 2 boxes per 180 days)
Invokamet
Jardiance
Northera
Purixan
Sitavig
Tanzeum
Zydelig

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