VMC

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comments

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MVP HEALTH CARE℠

www.mvphealthcare.com

Read any good newsletters lately?

Section 4 of the *MVP Health Care Provider Resource Manual* (Provider Responsibilities), states that we will notify you of all policy and procedure changes in a timely manner as stated in your contract.

- MVP's *Healthy Practices* newsletter is published six times per year. We time the mailing of each issue to include as many updates as possible and minimize the amount of mail we send to you.
- It is important that you (and others in your practice) take time to read each issue of this newsletter so that you can be aware of upcoming changes that will affect your practice.

Healthy Practices *is more than a newsletter; it's a notification document that is essential to doing business with MVP!*

If you have any questions or comments about the newsletter, please contact your MVP Professional Relations Representative.

Get *Healthy Practices* via email

Healthy Practices is going green! If you would like to opt in to receive *Healthy Practices* electronically, simply visit **www.mvphealthcare.com/providerpreferences** and complete the e-newsletter form.

Feel free to contact us at **ecommunications@mvphealthcare.com** with any questions.

RADIOLOGY PROGRAM UPDATES

As of April 1, 2012, MVP Health Care has contracted with CareCore National to manage the radiology utilization review process.

Advanced radiology scheduling service begins October 1

MVP is committed to helping members make informed choices about their health care. We will expand our relationship with CareCore National to include a concierge service to assist members with scheduling advanced radiology services (MRI, MRA, CAT and PET scans). This new scheduling service will begin on October 1, 2012 (subject to all necessary regulatory approval).

How the service works

- Upon clinical approval of an authorization request, CareCore National will contact patients approved for a high-tech imaging service, walk them through the process of selecting where the service will be performed and contact the chosen site for an appointment.
- Members will receive information on quality and providers' participation with MVP (in- or out-of-network). Member requests for specific, participating facilities will be honored.
- CareCore National will send the authorization approval to the requesting provider, to the member and to MVP to support claims payment.

Physician office requirements

- To ensure that our members receive high-quality care, as of October 1 MVP will require all MRI/MRA, CT/CTA and PET machines used to render services to MVP members have accreditation by the American College of Radiology (ACR). This change aligns MVP's protocol with Medicare guidelines that

required machines to be ACR-accredited as of January 1, 2012.

- If your site is already approved to provide these services, you may continue to do so provided that you obtain ACR accreditation by October 1.
- Physician offices that are approved sites but do not have this accreditation or have not reported this accreditation to MVP as of October 1 **will be considered non-participating (non-par)**, out-of-network providers for these services.
- If you are not sure of your site's approval status, please contact your MVP Professional Relations Representative.
- MVP maintains a closed panel for high-tech radiological services; only prior-approved physician offices are eligible to participate.

Information for radiology facilities

- Effective October 1, MVP will require radiology facilities that perform MRI/MRA, CT/CTA and PET scans to be credentialed with MVP.
- If your facility is already approved to provide these services, you may continue to do so provided that you complete the MVP credentialing process by October 1.
- Facilities that are approved sites but are not credentialed with MVP as of October 1 will not receive prior authorization through CareCore National to perform these services for MVP members on or after that date **and will be considered non-participating (non-par)**, out-of-network facilities for these services.
- If you are not sure of your site's credentialing status or want to begin the credentialing process, please contact your MVP Professional Relations Representative.

Radiation therapy management begins October 1

To help ensure appropriate use of new technologies and also to improve patient safety, MVP will expand the list of outpatient radiation services for which prior authorization is required to include radiation therapy services (Oncology and Radiation Oncology) as of October 1 (subject to all necessary regulatory approval).

- A list of the CPT® codes that are part of this initiative will be posted to the MVP website and also communicated in an upcoming issue of *Healthy Practices*.
- Providers will be required to submit their intended radiation therapy treatment plan via the web or by calling CareCore National for all CPT codes that require prior authorization. CareCore National will work with providers to ensure that treatment plans provide improved quality, safety and cost efficiency.
- CareCore National will relay a case number as proof of authorization for the service and treatment plan.

Using the CareCore National website

To be HIPAA compliant, MVP has determined that each individual who will access CareCore National's system must create a unique username and password. Offices should not share a username and password to access MVP's or our Business Partner's website.

To create a username and password on CareCore National's website, go to **www.carecorenational.com**, click on *Register* and follow these steps:

Step 1: User Information	You will need to provide contact and user information. Required Information: Contact Name, Address, Phone, Email *If an individual does not have a company email address, they must register for a web-based email address such as Yahoo or Hotmail before starting this process.*
Step 2: Provider Information	Enter information for each physician you want to tie to your account. Required Information: Tax ID, NPI or MVP Provider ID Number *During this step, we will search our database and find matches to the physicians you enter. You will be asked to validate the data found for each physician.*
Step 3: Registration Complete	CareCore National will provide each individual with a username and password

To manage the individual usernames and passwords, a designated office administrator must securely maintain a list of usernames and passwords for each individual staff member. When a staff member leaves the practice or no longer needs access to CareCore National's website, the designated administrator must change the password in CareCore National's system for the appropriate username so the individual no longer has access to the system.

3D imaging requires prior authorization as of July 1

Please note that 3D imaging services (CPT® codes 76376 and 76377) require prior authorization through CareCore National for dates of service on or after July 1. These codes are called out on the list of imaging CPT codes that now require prior authorization that is available on the MVP website when you log into your account and go to *Online Resources*.

PROFESSIONAL RELATIONS UPDATES

Auditing of professional services claims

MVP Health Care has contracted with OrthoNet to assist with our ongoing review of professional services claims.

MVP is launching a new claims auditing initiative that will go into effect on October 1, 2012 (subject to all necessary regulatory approval). The information in this issue of *Healthy Practices* serves as notice of the upcoming changes. Future issues of *Healthy Practices* will include additional detail.

- The initiative entails pending two types of claims for additional review: high-dollar procedure-based surgical claims (approximately 3 percent of surgical claims will be reviewed), and professional services claims from practices that may benefit from additional consultation on coding accuracy. Practices that are identified for this review will be individually notified by MVP that they are required to submit records for all claims.
- These reviews will be conducted by specialty-appropriate physicians and will follow nationally-accepted coding guidelines. It is important to note that these are NOT medical necessity reviews; only the accuracy of the coding of a particular set of services will be examined.
- For any claim that is pended for additional review, OrthoNet will contact you directly to request additional information, such as patient medical records or operative/clinical notes. Requested information must be submitted or the claim will be denied.

If you have any questions, please contact your MVP Professional Relations Representative.

Federal health care reform: Women's preventive care

Effective August 1, MVP will implement new coverage for women's preventive care services as part of the Patient Protection and Affordable Care Act (ACA). This coverage will be added to members' plans upon their groups' health plan renewal and to any new groups that join MVP.

As of August 1, MVP members will not be responsible for copays for the following preventive care services:

- Screening for gestational diabetes
- HPV testing w/ pap for women over 30
- Counseling on sexually transmitted infections
- Counseling and screening for HIV
- Contraceptive methods and counseling
- Female sterilization surgery
- Lactation counseling and equipment
- Screening and counseling to detect and prevent interpersonal and domestic violence

In addition, MVP will cover the purchase of a breast pump for new mothers. MVP will reimburse up to $75 for a manual or electric breast pump and will reimburse for one breast pump per live birth. MVP also will cover the replacement parts for the breast pump during the first year of the child's life.

Be sure to check each patient's benefits online by logging in at **www.mvphealthcare.com/provider** to confirm the correct cost-share for these services.

Reminder: MVP requires additional coding for immunization registry

As previously communicated, MVP is required to submit vaccine data to the State's immunization registry. Because the State needs to have encounter data that includes the vaccine CPT® code, MVP has begun requiring this coding on all claims. While the majority of vaccine claims we receive already include both the administration code and the appropriate vaccine CPT codes, some are still being submitted without this information.

In addition, MVP now requires that all vaccines are submitted on the claim form, even when the vaccine is supplied by the State. This will ensure we are providing the most accurate data to the State for the registry.

We have been and will continue to monitor claim reports to identify and schedule visits with offices that may need assistance in meeting this requirement. For example, we are finding that some offices were unaware that their clearinghouses are not submitting this line item information when they used $0.00 as a billed charge for State-supplied vaccines.

If you have specific questions about this requirement, please contact your Professional Relations Representative at **1-800-639-3881**.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the May and June meetings. Some of the medical policies may reflect new technology while others clarify existing benefits. All policy updates are listed online in the *Benefits Interpretation Manual* (BIM). Visit MVP online at **www.mvphealthcare.com**. Providers can directly access the online BIM through the *Reference* section of the *Provider* portal. 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.

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 **ww.mvphealthcare.com** in the *Reference* section.

Medical policy updates effective August 1, 2012

Ambulatory Holter Monitors/30-day Cardiac Event Recorders/Monitors: The policy has been updated to state the external electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording is considered not medically necessary. There is a Medicare variation for coverage of external electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording for specific indications outlined within the policy.

Artificial Heart: A Medicare Variation has been added allowing coverage of bridge-to-transplant as well as destination therapy when performed under coverage with evidence development (CED) when a clinical study meets criteria listed in the policy.

Cardiac Output Monitors for Thoracic Electrical Bioimpedence: There are no changes to the policy. Thoracic electrical bioimpedance is considered experimental/ investigational. Medicare allows coverage when criteria in the policy are met.

Cardiac Procedures: The policy was updated to state that catheter-based intracoronary brachytherapy is indicated only for in-stent re-stenosis.

Cardiac Rehabilitation Phase II: There are no criteria changes to the policy.

Cold Therapy Devices: There are no changes to the policy. Cold therapy devices are considered to be not medically necessary.

Emergency Department Services: Language has been added to the Emergency Department Services policy regarding court-ordered services. Court-ordered services do not meet the criteria of emergency services and are considered to be not medically necessary. An MVP Option and Option Family Variation has been added that allows coverage of court-ordered services.

Emergency Services: The Emergency Services policy is archived.

Foot Care: There are no criteria changes to the policy.

Home Uterine Activity Monitoring: There are no changes to the policy. Home uterine activity monitoring is considered not medically necessary.

Hyperbaric Oxygen Therapy (HBO): The policy was updated to include language that the member must be non-smoking during hyperbaric oxygen therapy treatment. The medical record must contain documentation that members must be non-smoking during hyperbaric oxygen therapy treatment.

Insulin Infusion Pumps: There are no criteria changes to the policy.

Light Therapy for SAD: There are no changes to the policy.

Magnetoencephalography: There are no changes to the policy. Magnetoencephalography and magnetic source imaging are considered investigational.

Mechanized Spinal Distraction Therapy: There are no changes made to the policy. Mechanized spinal distraction therapy is considered to be investigational. Other insurers including Medicare also consider it to be investigational.

Monitored Anesthesia Care: (NEW POLICY) The policy outlines the criteria for monitored anesthesia care during endoscopic procedures. Monitored anesthesia care is indicated when specific risk factors or significant medical conditions are present as listed in the policy.

Needle-free Insulin Injector: Denial rationale has been expanded to state that needle-free insulin injectors are considered not medically necessary as there are other alternatives for insulin administration available.

Nesiritide Infusion for Heart Failure – Outpatient: There are no criteria changes to the policy.

Pectus Excavatum: Indications/Criteria language regarding pulmonary function studies and cardiovascular or ventilatory limitation are as follows: Pulmonary function studies must demonstrate at least moderate restrictive (<80% FVC predicted) airway disease, or documentation of abnormal cardiovascular or ventilatory limitation, and CT Scan of the chest indicating a Haller index >3.25. The indication that the patient must be greater than three years of age has been deleted.

Phototherapy, Photochemotherapy, Excimer Laser Therapy: An Indication has been added under UVB Therapy for eczema/atopic dermatitis not responsive to topical or systemic drug therapies.

Pulmonary Rehabilitation (Respiratory PT): The policy has been updated to state that members will be considered for a maximum of 36 visits. A statement was added to the Overview that pulmonary rehabilitation services requested for an inpatient rehabilitation program must meet both the criteria for pulmonary rehabilitation and the criteria for acute inpatient rehabilitation admission.

Rhinoplasty: There are no criteria changes to the policy.

Sacral Nerve Stimulation: There are no changes to the policy.

Skin Endpoint Titration: The exclusion section has been updated to state that skin endpoint titration is considered not medically necessary if a member under age 16 has generalized skin symptoms such as hives and swelling after an insect sting.

Spinal Cord Stimulator for Intractable Pain: The following language has been added to the Exclusions section: spinal cord stimulators are not indicated for the treatment of any other conditions not listed under Indications/Criteria of the policy.

Transplants: Kidney/heart transplantation has been added as an indication. The following language has been added to the *Exclusions* section: "Multiple listings for organs i.e. registering at two or more transplant centers for a transplant organ is considered to be not medically necessary".

Vitiligo: There are no criteria changes to the policy. All treatment for vitiligo is considered cosmetic and, therefore, not medically necessary.

Wheelchairs (Manual): A statement has been added under Indications/Criteria clarifying coverage of ultra-lightweight wheelchairs (K0005) and accessories. Criteria were also added for customized pediatric strollers. An Exclusion has been added listing the accessories that are primarily used for the purpose of allowing the individual to perform leisure or recreational activities that are considered to be not medically necessary.

List of Medical Policies reviewed and approved in 2011 recommended for approval without changes in May 2012:

- Canaloplasty & Viscocanaloplasty
- Chiropractic Care
- Cryoablation of Breast Fibroadenomas
- EEG Monitoring and Anesthesia Awareness
- Immunotherapy for Recurrent Spontaneous Abortion
- Negative Pressure Wound Therapy Pumps
- Obstructive Sleep Apnea – Surgical Treatment
- Oncotype Dx Test/Breast Cancer Prognosis
- Temporomandibular Joint Dysfunction (TMJ) – NY/NH
- Temporomandibular Joint Dysfunction (TMJ) – VT
- Thermal Intradiscal Procedures (TIPS)
- Vision Therapy (Orthoptics, Eye Exercises)

List of Medical Policies reviewed and approved in 2011 recommended for approval without changes in June 2012:

- Artificial Intervertebral Discs – Cervical & Lumbar
- Benign Skin Lesions
- Capsule Endoscopy
- Deep Brain Stimulation
- Laminectomy, Hemilaminectomy – Lumbar Spine
- Medical Policy Development, Implementation, Review Process
- Septoplasty

Medical policy updates effective October 1, 2012

Obstructive Sleep Apnea – Diagnosis: (NEW POLICY)

- This policy addresses obstructive sleep apnea diagnosis
- Home sleep studies are covered for members without prior authorization
- Home sleep studies are required to be provided by an MVP contracted vendor (Sleep Management Solutions)
- Facility-based polysomnography is indicated if the member has a co-morbid complicating factor listed in the policy. Facility-based polysomnography requires prior-authorization.

Obstructive Sleep Apnea: Diagnosis Vermont and New Hampshire: Archived October 1, 2012

Obstructive Sleep Apnea: Diagnosis Vermont and New Hampshire medical policy will be archived effective October 1, 2012.

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

Preventive Drugs

Effective July 1, 2012, inhaled corticosteroids for the treatment of asthma will be added to the Preventive Drug list. Medications on this list are not applied to a member's deductible if the member has a high deductible health plan. A complete list can be found at **www.mvphealthcare.com**. Choose *Members*, then *Manage Prescriptions*, then *Preventive Drugs*.

Androgens/Anabolic Steroids

Testopel will be subject to a quantity limit of 10 pellets per administration for all lines of business. Previous communication referenced Medicare line of business only.

Policy updates

Adcetris (NEW POLICY)

- Establishes criteria for the treatment of certain types of lymphoma that follow NCCN guidelines and the package label

Androgens/Anabolic Steroids

- Policy updated to include quantity limits on androgens and anabolic steroids, including Testopel
- Option and Option Family variation was added

Antipsychotics for Depression (NEW POLICY)

- Establishes criteria for the use of Abilify, Seroquel XR and Symbyax for major depressive disorder for new starts only
- Policy does not apply to *Option and Option Family* members

ARB Therapy

- Step edit of an ACE prior to an ARB has been removed *(effective 5/15/2012)*
- Policy name changed to ARB Therapy
- Prior authorization is still required for non-formulary, Tier 3 ARBs

Cosmetic Drugs

- Egrifta was added as an exclusion for Option and Option Family
- The 31-year-old age limit for topical tretinoin products was removed *(effective 5/15/2012)*

Cough and Cold Products (Brands) (NEW POLICY)

- Prior authorization criteria includes failure on a similar generic product

Gralise (NEW POLICY)

- Criteria for the treatment of post-herpetic neuralgia includes but is not limited to disease for at least six months after rash has healed, minimum baseline intensity of at least 4 on an 11 point rating scale and failure, contraindication or intolerance to a 30-day trial of each of an immediate release gabapentin and a tricyclic antidepressant

Horizant (NEW POLICY)

- Criteria to include diagnosis of moderate-to-severe restless leg syndrome, a score of 15 or greater on the International Restless Legs Syndrome Rating Scale, failure on a one month trial to ropinirole or pramipexole and failure on at least a one month trial of immediate-release gabapentin

Intranasal Corticosteroids

- *Option and Option Family* variation added

Onychomycosis

- Terbinafine quantity limit has been changed to 90 units per 365 days *(effective 5/15/2012)*
- Prior authorization is still required for itraconazole (Sporanox) and ciclopirox (Penlac)

Pharmacy Programs Administration

- Medicare tier language was updated

Proton Pump Inhibitors

- Quantity limit for pantoprazole and lansoprazole (generic forms only) has been changed from 30 units in 30 days to 60 units in 30 days or 180 units in 90 days *(effective 5/15/2012)*

Quantity Limits

- Quantity limit for blood glucose test strips of 200 per 30 days or 600 per 90 days was added
- Quantity limit for smoking cessation products of two 90-day treatment courses every 365 days was added

Select Hypnotics

- Quantity limit has been changed from 15 units in 30 days to 30 units in 30 days *(effective 5/15/2012)*

Xolair

- Medicare variation added

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

- Agents for Pulmonary Hypertension
- Antibiotic/Antiviral Prophylaxis
- Cystic Fibrosis-Select Agents

The following policies were archived

Acne Products, Select Topical *(effective 5/15/2012)*
Leukotriene Modifiers *(effective 5/15/2012)*
Smoking Cessation Medications *(effective 5/15/2012)*

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
Cosopt PF	Open-angle glaucoma
Intermezzo	Middle-of-the-night awakening
Janumet XR D	Type 2 diabetes
Korlym†	Hyperglycemia in Cushing's Syndrome
Omontys	Anemia due to chronic kidney failure
Potiga	Partial-onset seizures
Qnasl	Rhinitis and seasonal allergic rhinitis
Subsys	Cancer pain
Suprenza	Weight reduction (short term)
Zioptan	Open-angle glaucoma

†Must be obtained from CuraScript for non-Medicare lines of business
D Diabetic copay

Generic drugs added to Formulary (Tier 1)

carba/levo/entaca (Stalevo)
clopidogrel (Plavix)
fluvastatin (Lescol)
ibandronate (Boniva)
ibresartan/HCTZ (Avalide)
irbesartan (Avapro)
modafinil (Provigil)
podofilox solution (Condylox)
quetiapine IR (Geodon)
vancomycin (Vancocin)

Drugs removed from the Formulary*

Avapro
Avalide
Plavix

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

Drugs removed from prior authorization^
(all medications are non-formulary, Tier 3 unless otherwise noted)

Duexis
Ella
Juvisync

Formulary updates for Medicare members

NAME OF DRUG	DESCRIPTION OF CHANGE Addition of drug to the formulary
Afinitor 7.5mg tabs[QL]	(Tier 4)
Creon 3-9.5-15K caps	(Tier 2)
escitalopram oxalate 5mg, 10mg, 20mg tabs	(Tier 1)
fluticasone propionate 0.05% lotion	(Tier 1)
ibandronate sodium 150mg tabs	(Tier 1)
Incivek 375mg tabs[PA]	(Tier 4)
progesterone 100mg, 200mg caps	(Tier 1)
sulfacetamide sodium 10% eye oint	(Tier 1)
trimipramine maleate 25mg, 50mg, 100mg caps	(Tier 1)
Victrelis 200mg capsules[PA]	(Tier 4)
ziprasidone 20mg, 40mg, 60mg, 80mg capsules	(Tier 1)

QL = Quantity Limit, PA =Prior Authorization

UTILIZATION MANAGEMENT UPDATES

Financial incentives relating to Utilization Management policy

It is the policy of all of the operating subsidiaries of MVP Health Care, Inc. to facilitate the delivery of appropriate health care to our members and to monitor the impact of the Plan's Utilization Management program to detect and correct potential under- and over-utilization 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 barriers to care and services.

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 UM staff, for issuing denials of requested care.

Financial incentives, such as annual salary reviews and/or incentive payments do not encourage decisions that result in underutilization.

Annual review of UM clinical criteria

InterQual® criteria, published by McKesson® Health Solutions, is used in many of MVP's medical review processes to support the medical necessity of health care services. On an annual basis, MVP opens a 15-day comment period on the criteria to health care providers. A copy of the InterQual criteria changes is available on the MVP website at **www.mvphealthcare.com/provider/ny/reference.html** until July 13 for your review, comments and questions.

If you have questions about the changes, you may speak to the MVP Medical Director by calling **585-327-2316.** The effective date of the criteria change will be communicated in a subsequent *FastFax* or issue of *Healthy Practices*.

2012 Ambulatory Surgery Procedure and *In-Office Procedure* lists

Effective August 1, 2012: The *2012 Ambulatory Surgery Procedure* and *In-Office Procedure* lists were approved by the Quality Improvement Committee in May and will be effective August 1.

Coverage for the ambulatory procedures is limited to the ambulatory surgery, out-patient hospital, or in-office settings. Claims submitted with a place of service other than these settings will be denied unless prior authorization is obtained. Use of appropriate place of service setting does not override any existing prior authorization requirements.

Coverage for in-office procedures is limited to the in-office place of service. Claims submitted with a place of service other than the in-office will be denied unless prior authorization is obtained.

The *2012 Ambulatory Surgery Procedure* and *In-Office Procedure* lists are located on the MVP website at **www.mvphealthcare.com/provider/ny/reference.html.**

QUALITY UPDATES

Provider Quality Improvement Manual (PQIM) update

Clinical Guidelines Re-endorsed

The MVP Quality Improvement Committee (QIC) recently re-approved the following enterprise-wide clinical guidelines:

Adult Preventive Care

MVP Health Care's Adult Preventive Care Guidelines, last updated in their entirety in 2011, underwent a recent review to align with the *Screening for Cervical Cancer* recommendation published by the US Preventive Services Task Force (USPSTF) in March 2012. This, as well as the other USPSTF recommendations on which MVP's Adult Preventive Care guidelines are based, can be found at **www.uspreventiveservicestaskforce.org/recommendations.htm**. Also within MVP's guidelines is an easy-to-follow table with key USPSTF recommendations

for men and women. For adult immunizations, MVP endorses the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) recommendations. A copy of their Immunization Schedule is available online at **www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm**. To view changes since the last update, click on *Changes* in schedule since last version.

Chronic Obstructive Pulmonary Disease (COPD)

MVP has adopted the Global Initiative for Chronic Obstructive Lung Disease's (GOLD) clinical guideline: for the Diagnosis, Management, and Prevention of COPD (2011 update). This can be found on the GOLDCOPD website at **www.goldcopd.com**. Click on the *Guidelines & Resources* icon located under the *Home* icon on the GOLDCOPD homepage. Also available at this site is a *Pocket Guide to COPD Diagnosis, Management, and Prevention and Spirometry Guide.*

In conjunction with these guidelines, MVP offers a Condition Health Management program for our members with a diagnosis of COPD. To refer one of your patients to this program, please call the Health Care Operations Department at **1-866-942-7966**.

Diabetes

Guidelines for our New York Practitioners were developed in collaboration with other health plans across the state. The easy-to-reference, one-page document is available in the PQIM along with a sample diabetes flow sheet. In Vermont, MVP endorsed the Vermont consensus guideline created by the Vermont Department of Health. These recommendations can be found at: **http://healthvermont.gov/prevent/diabetes/documents/DiabetesGuide0109.pdf.**

Both the NY and VT guidelines are based off the recommendations of the American Diabetes Association (ADA). For additional information, please refer to the complete 2012 recommendations which can be found at **http://care.diabetesjournals.org/content/35/Supplement_1.**

In conjunction with these guidelines, MVP Health Care offers a Condition Health Management program for our members with a diagnosis of Diabetes. If you would like to refer one of your patients to this program, please call the Health Care Operations Department at **1-866-942-7966.**

End Stage Renal Disease (ESRD)

MVP has adopted guidelines for End Stage Renal Disease (ESRD) based on the National Kidney Foundation's Kidney Disease Outcome Quality Initiative (NKF KDOQI™).

For all KDOQI Guidelines for Chronic Kidney Disease (CKD) Care and KDOQI Guidelines for Dialysis Care please go to the National Kidney Foundation website at **www.kidney.org/professionals/kdoqi/guidelines_commentaries.cfm#.**

In conjunction with these guidelines, MVP offers a Condition Health Management Program, the *Dialysis Support Program*, for members with End Stage Renal Disease who are preparing for or receiving dialysis. To refer one of your patients to this program, please call the Health Care Operations Department at **1-866-942-7966**.

Oncology

MVP has adopted the National Comprehensive Cancer Network's (NCCN) Practice Guidelines in Oncology™ for the treatment and management of cancer.

Providers may access the NCCN Clinical Practice Guidelines in Oncology™ online at **www.nccn.org**. On the NCCN home page, follow the *Clinical Recommendations* link and complete the brief registration process (free of charge). Numerous guidelines for the treatment and management of cancer are available by clicking on the link, *NCCN Guidelines for Treatment of Cancer by Site*. Also available under the *NCCN Guidelines®* link are several pocket guidelines available free of charge.

In conjunction with these guidelines, MVP offers a Condition Health Management program for members in active treatment for cancer. To refer one of your patients to this program, please call the Health Care Operations Department at **1-866-942-7966**.

Perinatal Care

MVP has adopted Perinatal Care practice guidelines as part of its continuing Quality Improvement Program. These practice guidelines primarily reflect the recommendations put forth in the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (AAP/ACOG) Guidelines for Perinatal Care, Sixth Edition. October, 2007.

The AAP/ACOG guidelines are available on the ACOG website. The guidelines are free to ACOG members. Non-members and members of the public can purchase the guidelines in printed form at the online store. To access any of the ACOG practice guidelines via the Internet go to the ACOG homepage and follow the publications link to guidelines: **www.acog.org**.

In addition to the AAP / ACOG guidelines, all clinicians who provide care for MVP Option and MVP Option Family (Managed Medicaid and Family Health Plus) patients should be aware of, and follow, the New York State Medicaid guidelines. To access the New York State Medicaid prenatal care guidelines online, go to

www.nyhealth.gov/health_care/medicaid/standards/prenatal_care. These standards were first developed in 2000 to follow the AAP / ACOG recommendations while incorporating the special needs of the Medicaid population. They were subsequently revised, (Chapter 484 of the laws of 2009; Public Health Law and Social Services Law) eliminating PCAP designation, certification and enhanced rates and authorizing establishment of new prenatal care practice management standards for all Medicaid providers.

In conjunction with these guidelines, MVP offers a Case Management high-risk prenatal care program, as well as a low-risk maternity Health Management program. Both programs are called *Little Footprints*. To refer one of your patients to either of these programs, please call the Health Care Operations Department at **1-866-942-7966**.

MVP updates its clinical guidelines at least every two years. The review process is also initiated when new scientific evidence or national standards are published. Paper copies of these recommendations are available by calling MVP's Quality Improvement (QI) department at **1-800-777-4793, ext. 12602**. The recommendations will also be available in an update to the MVP *Provider Quality Improvement Manual.* The current edition of the manual is located on the provider home page of the MVP website at **www.mvphealthcare.com/provider/qim/index.html.**

Continuity and Coordination of Care

MVP considers communication and coordination among health care providers essential to integrating quality, safety and continuity of care — all of which help to reduce medical errors. Consider these simple tips for improve continuity and coordination of care for every patient.

Primary Care Physicians

- Follow up with referrals for reports/hospitalizations
- Review, date and initial reports in patient's record prior to filing
- File reports in a timely manner

Specialists

- Send referral reports in a timely manner
- Send a copy of consult reports/hospitalizations to the patient's physician
- Ensure that the physician is notified of any changes in the member's medical condition

CLAIMS UPDATES

Claim entry on the MVP website

MVP Health Care previously maintained an online claim entry feature as a means of electronically submitting claims. This "web claim form" was taken offline on June 1 because it did not meet HIPAA 5010 standards. Health care providers who used this feature must now submit claims to MVP via another method.

You have the option of submitting claims via paper or electronically through EDI transactions. If you need help to begin sending claims electronically, please contact MVP's EDI Services Unit at **1-877-461-4911**.

MVP accepts only claims that follow Version 5010 standards

The original compliance date set by CMS by which health care providers were to adopt Version 5010 standards for claim submission was January 1, 2012; however, CMS extended that deadline to June 30, 2012. Please be aware that as of July 1, MVP no longer accepts Version 4010 data values. All data values on paper and electronic claims must be submitted in the valid 5010 format. Links to educational resources about Version 5010 are on the CMS website at **www.cms.gov** under *Regulations and Guidance*.

CMS encounter data and Medicare claim submissions

Encounter data includes all of the health care services listed on every claim submitted to MVP Health Care. CMS uses encounter data in many ways. For example, it is used to create a risk adjustment model that calculates payments to Medicare Advantage plans like MVP. Also, it will be combined with Medicare fee-for-service data to fight fraud.

CMS announced that, as of January 1, 2012, it is reviewing more encounter data on every Medicare claim—from just six data elements to over 2,000 on each claim.

Upgrading to Version 5010 standards for electronic health transactions will help ensure that Medicare claims provide acceptable encounter data for CMS to evaluate. Now that the CMS grace period for providers' adoption of 5010 has passed (June 30), please be aware that your practice may experience an increased rate of claim rejection related to the new format and file editing that are part of the new standards. You should expect these claim rejections to lessen as you become more accustomed to applying the new standards.

CARING FOR OLDER ADULT PATIENTS

Medicare physician signature requirements

The Centers for Medicare & Medicaid Services (CMS) have signature requirements for physicians. The purpose of the physician's signature in the patient's medical record is to demonstrate that the services submitted were accurately documented and reviewed. It also confirms that the physician has certified the medical necessity of the services that are submitted to Medicare.

According to CMS requirements, valid physician signatures must:

- be legibly handwritten; and
- contain physician's full name, date and credentials.

Electronic signatures must include one of the following statements:

- Approved by
- Authenticated by
- Electronically signed by
- Reviewed by
- Signed by
- Validated by

Please take a moment to ensure that your signature complies with these CMS signature requirements, to help avoid unnecessary denials, rejections or overpayment situations.

For more information on physician signature requirements, refer to the *CMS Medicare Program Integrity Manual* at **www.cms.gov/manuals/downloads/pim83c03.pdf.**

Recommending and monitoring physical activity

In the 2012 NCQA Health Outcomes Survey, Medicare members will be asked if, in the past 12 months, their health care provider discussed physical activity with them and whether the provider advise them to start, increase or maintain levels or physical activity. These questions will measure the Medicare Advantage Plan provider's involvement in monitoring the physical activity of their patient. The results are included in the annual HEDIS and CMS Star Ratings.

Daily physical activity can reduce the risk of developing or dying from some of the leading causes of disease and death in the United States. Regular exercise helps to:

- Reduce the risk of heart disease, depression, and anxiety.
- Reduce the risk of developing cardiovascular disease, diabetes, metabolic syndrome, colon cancer, and high blood pressure.
- Control high blood pressure in those who already have it.
- Build and maintain healthy bones, muscles, and joints. Muscle-strengthening exercises can also reduce the risk of falling and fracturing bones in older adult patients, which improves their ability to live independently.
- Control or maintain weight.
- Increase longevity.
- Promote a sense of general well-being.

It is important to discuss physical activity with your patients at each visit, both to ensure that they get responsible clinical advice on the appropriate level of exercise and that you provide the most conscientious level of care.

SPECIAL SECTION / PLEASE DETACH AND SAVE No NH

Medications considered "high risk" for the elderly

The Centers for Medicare and Medicaid (CMS), The American Geriatrics Society, and the National Committee for Quality Assurance (NCQA) caution the use of certain high-risk medications in your patients 65 years and older. Use of high-risk medication can increase morbidity and mortality, decrease quality of life, and lead to preventable health care costs. 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 is not intended as a substitute for clinical judgment. It is available online at **www.mvphealthcare.com/provider**. If you have any questions, please e-mail an MVP clinical pharmacist at **RxAdvisor@mvphealthcare.com**.

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	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 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.

DRUG CLASSIFICATION	HIGH-RISK MEDICATIONS	REASON FOR RISK	ALTERNATIVES
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.
Non-benzodiazepine 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; limit to short-term use (no more frequently than twice per week).
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	Hisk 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 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.	**Dementia:** donepezil, galantamine, rivastigmine, Exelon. **Stroke prevention:** aspirin, Plavix, Aggrenox