HEALTHY PRACTICES™

New York

VOLUME 8
NUMBER 2
MARCH/APRIL 2013

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

in this issue

contacting professional relations

MVP Corporate Headquarters (888) 363-9485
Southern Tier (800) 688-0379
Central New York (800) 888-9635
Midstate (800) 568-3668
Mid-Hudson (800) 666-1762

Denise V. Gonick
President and CEO

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

comments

Write to:
Healthy Practices
MVP Health Care, Inc.,
Professional Relations Dept.
PO Box 207, Schenectady, NY 12301

MVP® HEALTH CARE

www.mvphealthcare.com

Healthy Practices delivered to your email

To reduce our impact on the environment and minimize the amount of mail that we send to our providers, MVP Health Care® is converting our printed newsletters to email. If you have an MVP online account, you are receiving *Healthy Practices* at the email address associated with that account. To receive communications at a different email address, or if you have not registered for an online account but would like to enroll in MVP e-communications, please complete this form: **www.mvphealthcare.com/providerpreferences**. If you have any questions or choose to opt out at any time, please email **ecommunications@mvphealthcare.com.**

RADIOLOGY PROGRAM UPDATE

Advanced imaging member scheduling program changes

MVP Health Care® implemented a member scheduling program in October, 2012. The program was a member advocacy program designed to assist members in scheduling their advanced imaging appointments. It also provided information to our members regarding the accreditation status of advanced imaging facilities and potential variation in out-of-pocket costs under their MVP health benefit plans.

MVP will modify the member scheduling program

- MVP received feedback from providers and members regarding the program. We listened to that feedback and, after careful consideration, have decided to modify the program.
- Effective Friday, January 25, the member scheduling program will be available to members on a voluntary basis only. Members may elect to initiate contact with CareCore National if they desire assistance with scheduling appointments. However, the member scheduling process will no longer be included in the advanced imaging prior authorization process.

Provider site selection

- Effective Friday, January 25, the prior authorization process will be modified so that ordering providers are given information regarding the preferred status of MVP participating providers.
- Ordering providers may select any MVP participating provider to perform advanced imaging services for their patients.
- This change will be incorporated into the existing telephonic and web-based authorization request processes.
- Upon receipt of authorization, ordering providers will now be able to immediately schedule advanced imaging services for their patients.
- CareCore National will no longer make outbound calls to members to schedule appointments.

MVP continues to believe that it is important to engage our members in active participation in their health care choices to ensure that they receive the highest quality, clinically appropriate and cost effective services. We will continue to explore methods of educating our members about their health

plan benefits, of promoting transparency as they access health care services and of removing unnecessary costs from the health care system.

We thank you for your feedback regarding this program and for your continued participation with MVP Health Care.

POPULATION HEALTH MANAGEMENT UPDATES

Improving asthma care for MVP members

MVP Health Care analyzed data on members with asthma who visited the emergency room (ER). Our research shows that many members are non-adherent with their asthma medications, or that their asthma is inadequately controlled on their medications. MVP will begin outreach to health care providers in the coming months to address member medication compliance, focusing on members of our Commercial and Medicaid health plans.

If your patient's asthma is not well controlled, MVP has Health Managers (Registered Nurse and Registered Respiratory Therapist) to work with your MVP patients. A Certified Case Manager or Wellness Coach will offer information on lifestyle changes to help your patient minimize triggers, maintain an appropriate medication routine and more. Your patient will receive helpful information by mail about managing asthma with follow-up phone calls to answer questions and offer support. To make a referral, please call **1-866-942-7966, fax 1-866-942-7785** or email **PHMReferrals@mvphealthcare.com.**

Raising antibiotics awareness

Antibiotics are not always the easy answer to being well. MVP recently partnered with the Vermont Department of Health and Vermont-area insurers to promote the *Get Smart About Antibiotics* campaign created by the Centers for Disease Control and Prevention (CDC).

MVP's focus is on urging all of our members (regardless of whether they live in Vermont) to talk with their doctors about when an antibiotic will help their condition, or if their condition is most likely caused by a virus that cannot be treated by an antibiotic. In addition to educational articles in all of MVP's spring 2013 member newsletters, we created a new web page to promote the campaign and link members to helpful information on the CDC website. To visit this web page, go to **www.mvphealthcare.com**, click *Live Healthy* at the top of the home page, then click the *Antibiotics* link on the left side of that page.

MVP's depression care program now managed by ValueOptions®

MVP Health Care retired its depression care management program as of January 1, 2013. Depression management services for MVP members are now offered by ValueOptions, a trusted partner of MVP and a leader in behavioral health services. High-risk members that were enrolled in MVP's Depression Care Program prior to January 1 are continuing their care management though MVP. Members that were enrolled in MVP's low-risk mailing program are now receiving information and support from ValueOptions. Members may continue to self-refer by contacting the MVP Population Health Management Department at **1-866-942-7966**. Providers may continue to make depression care referrals by calling that number. MVP will then work with ValueOptions for member outreach and enrollment. This change is reflected in MVP's updated *Provider Resource Manual* (June 2013).

PROFESSIONAL RELATIONS UPDATES

MVP requests your feedback: ICD-10 readiness

MVP Health Care is preparing for the transition to ICD-10 in 2014. We are interested in our participating health care providers' progress toward ICD-10, also.

Please complete our short online survey about your ICD-10 readiness. Simply go to **www.mvphealthcare.com/provider** and click the ICD-10 readiness survey link on the right side of the page. Your feedback will help us implement education and outreach to help our participating providers as we all get ready for the October 2014 adoption deadline set by CMS. We appreciate your time!

OrthoNet professional service claims audit

As communicated in the July/August 2012 issue of Healthy Practices, MVP engaged OrthoNet to review the coding accuracy of certain surgical claims. That review program was effective as of October 1, 2012. Claims with dates of service occurring on or after October 1, 2012, may be subject to this review. OrthoNet will contact your office to request additional information, if needed, to complete this review of selected claims.

Radiation therapy management

As communicated in the July/August 2012 issue of *Healthy Practices*, MVP engaged CareCore National ("CareCore") to perform pre-service medical necessity reviews of radiation therapy treatment plans.

Prior Authorization: therapy plans initiated for services rendered on or after 10/29/12

Radiation therapy treatment plans initiated on or after October 29, 2012 require prior authorization from CareCore. Prior authorization requests can be initiated by calling CareCore at **1-866-665-8341**. Radiation therapy prior authorization history and status may be viewed at **www.carecorenational.com**. Claims for radiation therapy initiated and rendered on or after October 29, 2012 will be denied if prior authorization was not obtained.

Registration: treatment plans initiated prior to 10/29/12

Radiation therapy treatment plans that were initiated prior to October 29, 2012 are required to be **registered** with CareCore to ensure claim payment. Claims for radiation therapy services initiated prior to October 29 (with continuation of services rendered beyond that date) will not be paid unless those cases are registered with CareCore. Registration of radiation therapy plans for services that began before October 29 may be obtained by calling CareCore at **1-866-665-8341**. When registering such cases be certain to advise CareCore that the treatment plan was initiated prior to October 29, 2012.

Audiologists required to be contracted with MVP

Effective July 1, 2013 MVP will require all audiologists that provide services to MVP members to be contracted and credentialed to remain participating with MVP. Audiologists who do not meet these requirements as of July 1 will be considered non-participating providers. MVP will be sending out contractual agreements to all audiologists in our service area that have served MVP members in the past. If you have already signed a contract with MVP for audiology services, no action is required on your part. If you have not received a copy of this contract, please contact your Professional Relations Representative.

Prior authorization for skilled nursing stays

As a reminder, all skilled nursing facility (SNF) stays require prior authorization from MVP. Please complete a Prior Authorization Request form, available on our website at **www.mvphealthcare.com/provider/ny/forms.html** in the *Prior Authorization, Referral and Admissions* section of the page. Forms may be submitted by fax to **1-866-942-7826** or by mail to MVP Health Care, Utilization Management, 625 State Street, Schenectady, NY 12305. To submit a prior authorization request by phone, please call **1-800-999-3920.**

MVP annual notices

As part of our commitment to the accreditation standards of the National Committee for Quality Assurance (NCQA), and to comply with state and federal government regulations, MVP publishes an annual summary of important information for practitioners and providers. This notice includes the following topics:

- MVP's recognition of members' rights and responsibilities
- Complaints and appeals processes
- Confidentiality and privacy policies, including measures taken by MVP to protect oral, written and electronic PHI
- Medical management decisions
- Pharmacy benefit management
- Transition of patient care
- Emergency services
- Assessment of technology
- Medical record standards and guidelines
- Information about MVP's Quality Improvement Program
- Reporting suspected insurance fraud and abuse
- MVP's stance on physician self-treatment and treatment of immediate family members
- MVP's efforts to meet members' special, cultural and linguistic needs

To access MVP's annual notices for health care providers, visit the MVP website at **www.mvphealthcare.com** and click the *Privacy and Compliance* link in the green bar at the bottom of the home page. If you would like to receive a printed copy of this information, please call Professional Relations at the phone number shown on the left side of the this newsletter's front page.

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 FHP contracts. Following is a list of these access standards (also available in Section 4 of the MVP *Provider Resource Manual* titled *Provider Responsibilities*).

Action requested

It is important for health care providers to submit changes in participation or demographic information to MVP as outlined in this article. MVP also will contact you to do our own internal access and availability survey and to confirm your demographics.

Obtaining provider data forms

Provider data forms are available on the MVP website. Go to **www.mvphealthcare.com**, click on *Providers*, then *Forms* in the top green toolbar. Once you click through to the *Forms* page, go to the *Provider Demographic Change Forms* section. For a direct link to the provider data change form, type the following into your web browser: **www.mvphealthcare.com/provider/documents/contracted_provider_change_info.pdf.**

Submitting provider data changes or registrations to MVP

Please fax *Provider Registration* forms, *Contracted Provider Change of Information* forms or *Mid-Level Practitioner Registration* forms to MVP's Provider Data Management team at **518-388-2200.**

MEDICAL HEALTH ACCESS STANDARDS

Type of Service	MVP Commercial and all NH Products	New York State DOH: MVP Option, MVP Option Child and MVP Option Family	CMS: Medicare Advantage Products	Vermont Rule 10
Emergent Medical (Read further for definitions of "emergency")	Immediate access	Immediate access	Immediate access	Immediate access
Urgent Medical (Read further for definitions of "urgent")	Within 24 Hours	Within 24 Hours	Within 24 Hours	Within 24 Hours
PRIMARY CARE Non-urgent "sick" visit		Within 48-72 hours (Measure within 3 calendar days)		
Routine symptomatic: Non-urgent, non-emergent	Within 2 Weeks	Within 2 Weeks	Within 1 Week	Within 2 weeks with prompt F/U including referrals as needed
Routine asymptomatic: Non-urgent & preventive care appointments (NYSDOH) routine & preventive (CMS)		Within 4 weeks	Within 30 days	
Preventive care, wellness visits including routine physicals (CM, VT) Adult (>21) baseline & routine physical (NYSDOH)	Within 90 Days			Within 90 days
Initial assessment		Within 12 weeks of enrollment		Within 90 days of enrollment (good faith effort by plan)
Well child care		Within 4 weeks		
Initial PCP OV for newborns		Within 2 weeks of discharge from hospital		
Wait in PCP office (max)	30 minutes	1 hour	30 minutes	
After-hours care	24/7 availability or coverage	24/7 availability or coverage	24/7 availability or coverage	24/7 availability or coverage
Other Medical Care Initial prenatal visit:				
1st trimester		Within 3 weeks		
2nd trimester		Within 2 weeks		
3rd trimester			Within 1 week	
Initial family planning		Within 2 weeks of request		
Specialist referrals		Within 4-6 weeks (non-urgent) of request		
Routine lab, x-ray & general optometry				Within 30 days

WEB UPDATE

Updates to patient information accessible online

MVP is updating its online content for health care providers to ensure that the code descriptions we display are consistent with codes that are used in transmitting electronic (5010) transactions. These updates are effective March 22, 2013 and will affect some of the information that you access when you log in to your account at **www.mvphealthcare.com.**

PCP Specialty/Taxonomy Code Description

PCP Details on the *Patient Information* page will display the HIPAA-compliant Taxonomy Code Description for the provider's specialty.

Benefit Summary

After searching for and selecting a member, the member's benefits on the *Benefit Details* page will display *Service Type* descriptions.

Claim Status

The claims summary status will display a HIPAA-compliant claim status category code.

Examples of revised claim status language:

"Completed" will now read "Finalized"

"Adjusted Complete" will now read "Finalized/Adjudication Complete"

"In process" will now read "Pending/In Process"

Deductible Amounts

A member's remaining deductibles will reflect HIPAA-compliant language and format changes.

For example:

Family deductible can include a Family Members Required option. In this type of deductible, once the stated number of members has met their deductible, it is considered to have been met, even if the total dollar amount for the family has not been met. For example:

- Member Amount 100
- Family Amount 350
- Family Members Required 3

In this example, once three family members have met their $100 deductible requirement, benefit payment will begin, even though the $350 entered as being the family amount has not been met. The deductibles will also be considered as satisfied when deductibles for all family members reach $350. For example, Family Members #1, #2 and #3 have each accumulated $90 toward the deductible, and Family Member #4 has accumulated $80, for a total of $350. No further charges will be applied to deductibles.

CREDENTIALING UPDATE

Hyperbaric Oxygen Therapy (HBOT) credentialing criteria update

MVP Health Care now has credentialing criteria for hyperbaric medicine centers and for physicians providing hyperbaric oxygen therapy (HBOT). Facilities and physicians treating MVP members using HBOT must fully comply with the requirements defined in the MVP Organizational Credentialing and Recredentialing Process policy and meet the criteria outlined here.

- All Hyperbaric Medicine Centers ("facilities") providing HBOT services will be required to provide proof that they have submitted an application for accreditation to the Undersea and Hyperbaric Medicine Society (UHMS) no later than July 1, 2013 and must achieve UHMS accreditation by July 1, 2014.
- After July 1, 2013, facilities that have not achieved UHMS accreditation or cannot submit proof that they have applied for UHMS accreditation will no longer meet MVP criteria and may not submit claims for services provided to MVP members.
- The final deadline for HBOT facility accreditation was extended to July 1, 2014.
- After July 1, 2014, facilities that have not achieved UHMS accreditation will no longer meet MVP criteria, and may not submit claims for services provided to MVP members.

Effective July 1, 2013, physicians providing HBOT services must attain and provide proof of:

- Board certification in Undersea and Hyperbaric Medicine by the American Board of Preventive Medicine (ABPM) or the American Board of Emergency Medicine (ABEM) **OR**
- Completion of a 12-month fellowship in Undersea and Hyperbaric Medicine. The fellowship must be accredited by a program recognized by MVP **OR**
- Documented proof of eligibility to take the ABPM or ABEM Undersea and Hyperbaric Medicine examination **OR**
- Affiliation with a Clinical Hyperbaric Facility accredited by or in the accreditation process with the Undersea and Hyperbaric Medical Society

As a reminder, the following interim facility and physician criteria are now in effect. Please note that these criteria will no longer apply as of July 1, 2014.

Facilities must:

- Be accredited as a Level 1, 2, or 3 Hyperbaric Treatment Center by the Undersea and Hyperbaric Medical Society **OR**
- Be part of an acute inpatient medical-surgical hospital fully credentialed by MVP per the MVP "Hospital Criteria" and the MVP "Credentialing of Organizational Providers" administrative policy **AND**
- Engage at least one physician who meets one of the approval pathways noted on the MVP

"Credentialing Criteria for Physicians Providing Hyperbaric Oxygen Therapy."

Physicians must provide documented proof of the following:

- Completion of a 40-hour course approved by the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society **AND**
- One year of active practice in Hyperbaric Medicine with a minimum of 25 percent of the time or 10 hours per week (whichever is greater) spent in Hyperbaric Medicine **AND**
- Documentation of a minimum of 100 cases treating the disease specific indications approved by Medicare and currently approved by the MVP medical policy.

To request a credentialing packet or if you have questions about this change, please contact your MVP Professional Relations or Facility Representative.

UTILIZATION MANAGEMENT UPDATE

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.

CARING FOR OLDER ADULTS

Your impact on patients' Health Outcome Survey (HOS) responses

The Centers for Medicare & Medicaid Services (CMS) requires health plans to monitor the care our members receive from their health care providers. As we have discussed in previous editions of this newsletter, the CMS Star Ratings include many measures that are associated with care given by physicians who care for MVP Medicare Advantage (MA) members.

Some of the measures are self-reported by your patients through a survey called the Health Outcome Survey (HOS). The HOS assesses each MA plan's ability to maintain or improve the physical and mental health functioning of its beneficiaries over a two-year period. The initial survey is sent to get baseline information on the patient's perception of their health.

The survey is sent to the same patients (if possible) after two years to assess changes in their physical health status. The survey includes questions that ask your patients if their PCP has talked to them about physical activity, about their risk of falls and about urinary incontinence. **CMS is expecting that an assessment of these issues is completed and that a treatment plan is in place to improve the quality of life for your patients if any issues are identified.**

The HOS also includes questions about their physical and mental well-being. Several questions are asked about their physical and mental health that compares results to how these patients responded to the survey done two years earlier. Assessment of a patient's physical and mental health is a critical part of any office visit.

The CMS star rating for these measures for the last reporting period are in the chart below.

MVP has developed some tools to assist physicians and their office staff that can be utilized for the above assessments. They can be found in the *Provider QI Manual* on our website.

CMS Measure*	Rochester HMO Members Results	Rochester PPO Members Results	East Region HMO Members Results	East Region PPO Members Results
Monitoring physical activity (discussed physical activity & PCP advised to start, increase or maintain level of exercise or physical activity)	2	2	3	3
Reducing Fall Risk (assess patient's risk of falling & development of a plan to reduce risk of falls)	4	3	1	3
Improving Bladder Control (assess patient for urinary incontinence & received treatment)	3	3	3	3
Improving or maintaining physical health	5	5	NA	4
Improving or maintaining mental health	2	3	NA	2

*Scores are rated 1 to 5 stars with 5 stars being the highest or best rating.

Go to **www.mvphealthcare.com**, click *Provider* and then *Provider Quality Improvement Manual* in the *Quality Programs* section of that web page. The direct link is **www.mvphealthcare.com/provider/qim/caring_for_older_adults.html.** The MVP Adult Preventive Care Guideline includes a matrix of preventive services recommended for care of the elderly.

Talk to patients about avoiding hospital readmission

In an effort to decrease readmission rates after a hospital stay, MVP is educating its Medicare Advantage plan members on how to be prepared for a smooth transition from hospital to home. Members who are better prepared before their visit will have a lower chance of having to be admitted back into the hospital because of a problem.

Providing continuity and coordination of care for a patient as they transition from the hospital setting to outpatient is also crucial in reducing hospital readmission rates. Health care providers can help by obtaining hospital discharge summaries in a timely manner and documenting any changes in medical/surgical history and medications. Often, after a hospital stay, a patient may have additional specialists involved in their care. It is important for primary care providers (PCPs) and specialists to communicate relevant information to ensure a coordinated approach to the patients care.

We encourage physicians to speak with MVP Medicare plan members about this important topic. Some helpful tips that members should follow include:

- Bring a complete list of medications to the hospital on the day of admission.
- Work with the discharge planning staff to make a hospital follow-up plan.
- Take an active role in discharge and treatment planning.
- Learn any important details about the condition and how they can take care of themselves.
- Schedule a follow-up appointment within seven days after leaving the hospital.
- Bring hospital discharge plan along with a list of medications to follow-up appointment(s).
- Carry important information at all times about the condition, medications, doctor and pharmacy contact information.

To help members keep important information with them at all times, MVP has created the *My Hospital Discharge Checklist* wallet card. It is available on our website at **www.mvphealthcare.com**. Click on *Medicare Members*, select the county in which your patient lives, then click on *Live Well* and *Useful Tips After a Hospital Stay.*

QUALITY UPDATE

Reports from MVP help enhance patient management

The MVP Quality Improvement Department offers primary care quality reports (produced at the practice site level) that can help you manage your patient population.

- The prospective Gaps in Care report identifies members who have not had preventive screenings, well care visits or immunizations. If a member is lacking services in multiple areas, the information is consolidated on one row to make it easier for you to ensure that all services are provided in a timely fashion. This report is produced three times a year.
- MVP also produces two emergency room (ER) utilization reports. One provides detailed information on members who have utilized the ER in the past month for care. The other report provides a list of members who have utilized the ER two or more times in the past month for care. These reports are produced monthly and are usually available around the 20th of each month.
- The Inpatient report provides a list of members who were discharged from the hospital during the previous month. The report lists the discharging hospital, the length of stay and diagnosis. This report also is produced monthly and is available around the 20th of each month.

MVP's reports are provided in an electronic format (Excel), allowing you to work with the data based on your particular need or interest. All of the reports that you request will be sent to you via MVP's secure email service (ZixMail) to ensure the protection of PHI.

If you would like to begin receiving these reports or have questions about any of the reports that you currently receive, please email:

Michael Farina, Associate Director Clinical Reporting, at **mfarina@mvphealthcare.com**.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the January 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 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 April 1, 2013

Bone Density Study for Osteoporosis (DEXA)

There are no changes to the medical policy.

Bone Growth Stimulator

The Indications/Criteria for the Ultrasound Bone Growth Stimulator now lists the types of bone fractures that are covered.

Compression Stockings

The following codes are not covered under MVP Option products: surgical stockings (A4495, A4500); gradient compression stockings (A6530, A6533 – A6541, A6544; and A6549; miscellaneous DME supply or accessory, A9999, not otherwise specified).

Speech Generating Devices

Communication boards have been added under accessories covered for speech generating devices.

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.

Medical policy updates effective June 1, 2013

Electrical Stimulation Devices & Therapies (NEW POLICY)

The policy follows Medicare's National and Local Coverage Determination. Coverage is allowed for TENS for chronic low back pain when criteria in the policy are met. Medicare does not allow coverage of TENS for low back pain.

CLAIMS UPDATE

National Drug Codes (NDCs)

Health care providers have asked how to bill NDC codes. What follows are answers to your most-asked questions.

NDC Formatting

- A valid NDC is submitted as an 11-digit code without any dashes.
- However, you will usually not see just 11 numbers when you look at an NDC on a medication package. This is because the 11 digits of an NDC are broken out into 3 sections:
  - The first 5 digits identify the drug manufacturer.
  - The next 4 digits identify the specific drug and its strength.
  - The last 2 digits are indicative of the package size.
- In some cases, you may see a "5 digit-4 digit-2 digit" code (example: 12345-1234-12).
  - In this situation, you will simply remove the dashes and submit the 11 numbers.
- You also may see other formats for NDCs, since many manufacturers omit leading zeros in one or more of the three NDC sections.
- For a claim to be paid, any leading zeros must be added back into the appropriate place within the NDC to create an 11-digit NDC number that matches the Medispan and/or First Databank databases.

Choosing the applicable NDC:

- Drug manufacturers are currently not allowing NDCs found on the inside packaging to be published. This means that the outermost NDC (on a box) should always be used for billing rather than the NDC found on an individual syringe or vial.

HERE'S HOW TO CONVERT YOUR NDC INTO THE "5-4-2" FORMAT AND HOW TO KEY IT ONTO THE CLAIM FORM BY ADDING THE N4 QUALIFIER:

Packaging NDC Format	Add leading zero(s) to the:	Conversion Examples	and is keyed as
4-4-2	First segment to make it 5-4-2	4-4-2=1234-1234-12 becomes 5-4-2=01234-1234-12	N401234123412
5-3-2	Second segment to make it 5-4-2	5-3-2=12345-123-12 becomes 5-4-2=12345-0123-12	N401234123412
5-4-1	Third segment to make it 5-4-2	5-4-1=12345-1234-1 becomes 5-4-2=12345-1234-01	N401234123412
3-2-1	First, second, and third segments to make it 5-4-2	3-2-1=333-22-1 becomes 5-4-2=00333-0022-01	N400333002201

NDCS ON CMS-1500 CLAIM FORMS

Instructions for filling out a CMS-1500 form

- NDC should be entered in the shaded area of fields 24A – 24G for the corresponding procedure code
- The following should be included in order
  - Report the N4 qualifier (left justified) followed immediately by:
  - 11 digit NDC (no hyphens)
  - One space followed immediately by:
  - Unit of measurement qualifier:
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter
    - UN - Unit

    followed immediately by:
  - Unit Quantity

    Quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal.

    Examples:
    - 1234.56
    - 2
    - 99999999.999

Example : N412345678901 UN1234.567

NDC Code:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N45914801665 UN1													N	1B	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

NDCS ON UB-04 FORMS AND ELECTRONIC CLAIM SUBMISSIONS

Instructions for filling out a UB-04 form

- NDC should be entered into field 43
- The following should be included in order
  - Report the N4 qualifier (left justified) followed immediately by:
  - 11 digit NDC (no hyphens) followed immediately by:
  - Unit of measurement qualifier:
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter
    - UN - Unit

followed immediately by:

- Unit Quantity (floating decimal, limited to three digits to the right of the decimal)

Example : N412345678901UN1234.567

Instructions for electronic claim submissions

Complete the drug identification and drug pricing segments in Loop 2410 following the instructions below.

Loop	Segment		Element Name	Information
2410	LIN	02	Product or Service ID Qualifier	Use qualifier N4 to indicate that entry of the 11 digit National Drug Code in 5-4-2 format in LIN03
2410	LIN	03	Product or Service ID	Include the 11-digit NDC (No hyphens)
2410	CTP	04	Quantity	Include the quantity for the NDC billed in LIN03
2410	CTP	05	Unit or Basis for Measurement Code	For the NDC billed in LIN03, include the unit or basis for measurement code using the appropriate code qualifier: • F2 – International Unit • GR – Gram • ML – Milliliter • UN – Unit

PHARMACY UPDATES

Therapeutic class changes

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

Antidiabetic agents

Janumet XR will be added to the formulary. Onglyza and Kombiglyze XR will be removed from the formulary and require prior authorization effective April 1, 2013.

Inhaled corticosteroids

Qvar will be added to the formulary. Flovent will be removed from the formulary. Prior authorization will be required for non-formulary agents Alvesco and Flovent effective April 1, 2013.

Inhaled corticosteroids/LABA combinations

Dulera will be added to the formulary. Advair will be removed from the formulary and require prior authorization effective April 1, 2013.

Urinary anticholinergics/antispasmodics

Toviaz and Vesicare will be added to the formulary. Prior authorization will be required for non-formulary agents effective April 1, 2013.

Policy updates (effective April 1, 2013)

Antipsychotics for Depression

- Step edit requirement language was clarified.

Compounded (Extemporaneous) Meds

- Language clarified that self-administered compounds must process through the PBM.
- All compounds, medical or pharmacy, over $250 require prior authorization.

Cox-2 Inhibitors

- Formulary language updated for Option/ Option Family.

DPP4 Inhibitors (NEW)

- New policy requiring prior authorization for non-formulary Onglyza and Kombiglyze XR.
- Criteria includes failure on formulary DPP4 agents.

Erivedge (NEW)

- New policy establishing prior authorization criteria that includes but is not limited to diagnosis of locally advanced or metastatic basal cell carcinoma, prescribed by an oncologist or dermatologist and age 18 or older.

Horizant

- New indication and criteria for the use in post-herpetic neuralgia was added. Criteria is the same as Gralise.

Hypnotics (select)

- Intermezzo was added to the policy with quantity limits.
- Select Medicare language was removed as new CMS guidelines allow coverage for select benzodiazepines.

Inhaled Corticosteroids and Combinations (NEW)

- New policy requiring prior authorization for non-formulary Alvesco, Flovent and Advair.
- Criteria includes FDA approved dosing and age requirements as well as failure on all other formulary covered drugs.

Mepron (NEW)

New policy establishing prior authorization to ensure appropriate utilization.

Migraine Agents

- Clarified prior authorization requirements on drug table.

Overactive Bladder (Oral) Treatment (NEW)

- New policy requiring prior authorization for non-formulary Sancture/XR and Enablex.
- Criteria include failure on formulary agents.

Pain Medication

- Subsys was added to policy.
- Language referring to the new REMS Program for Tansmucosal Immediate Release Fentanyl was added.
- Use of buprenorphine in combination with opioids was excluded.

Pharmacy Programs Administration

- Prescriber prevails provision added for atypical antipsychotics, for Option and Option Family business only.

Prescribers Treating Self and Family Members

- Contract language was updated.

Provenge

- Prostate cancer stats were updated. No changes to criteria.

Xyrem

- Use with alcohol added as an exclusion.

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

- Gralise
- Mail Order
- Physician Prescriptions Eligibility
- Qutenza
- Sabril
- Vimovo

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
Aubagio	Multiple sclerosis
Linzess	IBS-C and CIC
Synribo*	Chronic myeloid leukemia
Ultresa	Exocrine pancreatic insufficiency
Viokace	Exocrine pancreatic insufficiency
Xeljanz	Rheumatoid arthritis

**Medical drug*

Generic drugs added to Formulary (Tier 1)

betamesthasone foam (Luxiq)
candesartan-HCTZ (Atacand HCT)
fenifibrate (Tricor)
glimepiride-metformin (Duetact)
griseofulvin ultra (Gris-Peg)
Lamictal XR (lamotrigine XR)
oxymorphone (Opana ER –old formulation)
phenytoin (Dilantin Chewable)
rizatriptan (Maxalt/MLT)
tranexamic acid (Lysteda)

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

Celontin
Duetact
Maxalt/MLT
Peganone
Tricor

**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)

Pertzye
Sorilux
Voraxaze*

**Medical drug*

MVP HEALTH CARE
P.O. Box 2207
Schenectady, NY 12301

your healthy practices newsletter is here!