Vermont

HEALTHY PRACTICES™

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

in this issue

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comments

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MVP® HEALTH CARE

www.mvphealthcare.com

Better information sharing for better patient care

COMING SOON FROM MVP!

This summer, MVP Health Care® will launch CareRadius, a web-based care management platform that offers real-time information sharing.

That's just the beginning. Coming in fall 2014 you will have access to CareAffiliate, an industry-leading technology designed to streamline communications with our network of health care providers.

Simply put, CareAffiliate enables better sharing for better patient care. Here are some features you can expect.

Online authorizations

- CareAffiliate will accept inpatient and outpatient medical and pharmacy authorizations
- The data entry form is simple and secure; you can attach documentation right to the online form and submit it directly to MVP for review

Secure online information sharing

- Inpatient and discharge notifications, as well as extension requests, can be submitted securely via CareAffiliate

Easy access

- CareAffiliate will be accessible to you when you log in to your online account on the MVP website. In order to make this technology more useful and seamless, you won't need to register for an additional username and password to access it.

CareRadius and CareAffiliate will enable simple, integrated care collaboration between MVP and health care providers. We look forward to sharing details about the launch of these tools, training opportunities and more in *Healthy Practices*.

EFT/ERA live!

MVP's solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs) through PaySpan is now live. This service is provided at no cost to you and allows online enrollment, saving you time and ensuring faster payments. To obtain your registration code, please contact PaySpan at **1-877-331-7154**, Monday–Friday, 8 am–8 pm Eastern Time.

Some updates to be aware of:

- You should have received an email or letter with registration information. If you have any questions, contact PaySpan at **1-877-331-7154**.
- Data Exchange Provider (DEP) information can be found at **www.mvphealthcare.com.** Click on *Provider* and view the information in the gray box at the top.
- EFTs will only be available for Medical claims payments. Occasionally, MVP needs to send additional monies to providers that don't go through an EFT and you will continue to receive a paper check. These situations include:
  - Medicare chart review incentives

Continued on page 2

- Capitation payments
- Recovery payments

In addition, MVP acts as a third party for members with Health Reimbursement Accounts (HRA) and some Flexible Spending Accounts (FSA). Because MVP makes these payments on behalf of these members, they will continue to come to you via check with a stub indicating the claim number and that it was paid.

Great reviews for myMVP mobile app

MVP members are downloading our free mobile app, myMVP, and enjoying the convenience of accessing the information they need from MVP – anytime, anywhere!

Current features of the myMVP app include:

- *Find a Doctor or Facility:* Users can find the nearest hospital, doctor's office or urgent care center by searching zip code or city, or utilizing their phone's GPS location search. myMVP also provides driving directions.
- *Search Claims:* Members can search and view claim details and payment status.
- *View ID Cards:* Members can access their ID cards, order replacements and email or fax a copy of their card.
- *Contact MVP:* A built-in contact feature allows users to quickly call or email MVP's Customer Care Center.

Class act

★★★★★ **by GolfMom2006**

This is great—simple yet very well done. Love being able to search for docs on the fly, and the convenience of having your ID card available on your phone is awesome!

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

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

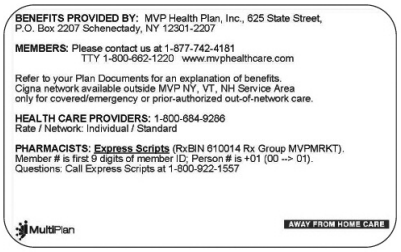
PROFESSIONAL RELATIONS UPDATES

Identifying Vermont Health Connect individual plan members

If you have questions about whether your patient has coverage as an individual through Vermont Health Connect or the network of health care providers that accept that patient's coverage, please refer to your patient's ID card and/or the patient eligibility information that MVP makes available online.

ID card – A Rate/Network indicator on the back shows that the member has an "individual/standard" or an "individual/non-standard" plan.

This same information is displayed on the ID card whether the member purchased coverage via the Marketplace. It does not affect the network or payment to providers.



More Member ID card images can be found in Section 3.17 of the *Provider Resource Manual* effective April 1, 2014.

Online patient eligibility – It is important to check every patient's eligibility when you log in to your account at **www.mvphealthcare.com/providers**. Search for the patient using the required information, then click on the patient's name to open *Patient Information*. Scroll down to the *Eligibility* section where the medical product name is listed. This will indicate whether the patient has an individual standard or individual non-standard plan.

Members and health care providers can use the *Find a Doctor* feature at **www.mvphealthcare.com** to find participating providers and facilities specific to a patient's health plan by inputting their MVP Member ID at the start of the search.

Advanced Premium Tax Credit (APTC) Marketplace members – grace period update

Previously, MVP shared that we will pend claims for services rendered to an APTC (subsidized) Marketplace member with an Individual MVP Premier or MVP Secure product when their delinquency exceeds one month. Claims for such members may be pended for a grace period up to three months of non-payment of their premium, after which their coverage will be terminated. The pending of claims was scheduled to begin on March 1, 2014; however, due to unforeseen circumstances the start date was pushed out to May 1, 2014. Claims will continue to be paid and providers will not be penalized due to MVP's delay in implementation.

APTC (Subsidized) Members

- APTC (subsidized) members will remain eligible for up to three months of non-payment of their premium, at which time they will become ineligible. MVP will put claims in a pend status after the initial month of delinquency until the three month mark, unless payment is received prior. This period of time is longer than prompt pay laws and most of MVP's contracts allow for; however, Federal ACA law supersedes contractual agreements and prompt pay laws, so prompt pay interest will not be applied.
- Federal guidelines state we must notify you of the possibility for denied claims when a member is in the second and third months of the grace period. These claims will be denied as "Member not Eligible," and the member may be billed directly for the service. You will receive a letter indicating that the member is in premium arrears for each claim received during the last two months of the grace period.
- Claim status can be checked at any time when you log into your account at **www.mvphealthcare.com** and perform a *Claim Inquiry*, which will show the claim as pended. Subsidized members who are delinquent with their premium in the second and third month of the grace period will show as eligible but with a note that indicates "Premium Payment Past due. Claims may be pended."

The specific notation "Premium payment past due. Claims may be pended." will appear in red on the Eligibility screen.

Notes regarding non-subsidized members (members who are not receiving the Advanced Premium Tax Credit (APTC):

Non-Subsidized Members

- Federal guidelines also dictate that these members may be delinquent with their premiums and still be considered eligible. Members will show as eligible online if they are delinquent for less than one month. Their claims will continue to be paid during the first month of delinquency.
- Non-subsidized members delinquent with premium payments for more than one month will become ineligible immediately, at which time you may bill the member directly.

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

Vermont uniform prior authorization form for medical procedures

In 2013, the Vermont legislature passed Act 171 that amended 18 V.S.A. § 9418b to include requirements for the development of a uniform prior authorization (PA) form to standardize prior authorization requests for prescription drugs, medical procedures (to include both physical and mental health conditions), and medical tests required by Vermont health insurers and Medicaid (Department of Health Access). The Department of Financial Regulation (DFR) was tasked to work in consultation with the Department of Health Access (DVHA), the Vermont Medical Society (VMS), and health insurers to develop a "clear, uniform and readily accessible" PA form for use by all relevant Vermont providers. The uniform PA form will be used for all types of medical treatment that require PA, including mental health and substance abuse.

DFR determined that the extent of the operational and clinical differences among health plans for authorizing prescription drugs were too complex to be effectively transformed to a standardized form. Each health insurer and DVHA will continue to use their own PA forms for pharmacy services.

According to statute, each insurer must accept either the national standard transaction information for PA's electronically via online portal or accept the uniform PA form approved by DFR for requests for medical procedures (including mental health services) and medical tests when prior authorization is required beginning on or after March 1, 2014. To review the statute go to **www.leg.state.vt.us** and click on *Vermont Statutes*, then *Title 18*, then *Chapter 221*, then *Section 9418b (Prior Authorization)*.

Providers may obtain a uniform medical or prescription drug prior authorization forms from MVP, including submission instructions and contact information, by visiting **www.mvphealthcare.com/providers**. Click on *Forms* for a complete list of prior authorization forms. The Vermont Uniform Prior Authorization Form for medical services can be found under *Prior Authorization, Referrals and Admissions*. Prior authorization forms for pharmacy services can be found under the *Pharmacy* section. **Providers requesting prior authorization must send or fax a completed form to MVP at 1-800-280-7346 in advance of the proposed services.**

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, tax id # changes

To report demographic changes to MVP please complete the Provider Demographic Change form. Go to **www.mvphealthcare.com/provider** then *Forms*, then *Provider Demographic Change Forms* and fax the demographic change form to your PR representative on letterhead or email your demographic changes to your PR representative. For more information see section 4 of the *Provider Resource Manual.*

POPULATION HEALTH MANAGEMENT UPDATES

Breastfeeding support

MVP recognizes the importance of breastfeeding babies and we are committed to ensuring that breastfeeding support is available for every mom and baby we cover. We have a new, comprehensive lactation support program providing breastfeeding support and equipment through Corporate Lactation Services.

Little Footprints℠

MVP offers a high-risk prenatal care program called *Little Footprints*. The program includes telephone calls from a registered nurse specializing in high risk maternity for one-on-one education, case management support and intervention during a high-risk pregnancy. The members receive a packet that includes an order form for a free copy of the book, *What to Expect When You're Expecting*. The packet also includes MVP's prenatal care guidelines, information regarding reimbursement of childbirth preparation classes, breast feeding, infant care classes, as well as education pamphlets. Members are followed post delivery and are assessed for post partum depression and a newborn assessment is completed. Members are advised to follow up with their physicians post delivery and verify that an appointment with the pediatrician has been scheduled.

MVP provides the same prenatal services to all MVP Option members who are pregnant. This program is referred to as *Little Footprints Option* for Medicaid members.

To make a referral to our Little Footprints program, call **1-866-942-7966**, fax **1-866-942-7785** or email **phmreferrals@mvphealthcare.com**.

Through this relationship with Corporate Lactation Services, MVP offers nursing mothers state-of-the-art breastfeeding equipment and access to internationally board certified lactation consultants and registered nurses 365 days-a-year. This support program includes outreach calls placed at specific times to provide mothers with information appropriate for the age of their infant/baby. Moms can call in with questions or concerns until weaning. All of these services are offered at no additional charge to our members.

Mothers can enroll when pregnant and while nursing. We suggest mothers enroll in the second or third trimester to receive the full benefit of the program. To enroll, mothers can:

- Visit **www.corporatelactation.com**, click *SUBSIDY LOGIN* then enter the pass code MVP2229
- Or contact Corporate Lactation Services directly at **1-888-818-5653** or **enroll@corporatelactation.com**

Talk with your patients about aspirin use

Aspirin use as treatment for heart disease is often misunderstood. The best resource for your patients is you. Talk with your patients about appropriate use of aspirin for the prevention of heart attacks. Without the benefit of your expertise, television commercials can be very persuasive and do not clearly explain the risks as well as the benefits. No one knows your patients better than you do, and they trust your recommendations.

Help your patients make the **right** decision. The American Heart Association's website offers more details, presented to a non-clinical audience, which may be a helpful resource for your patients.

Go to **www.heart.org** and type *"aspirin"* into the search box to connect with helpful web content and downloadable materials.

Prior notification requirement lifted for inpatient maternity services

As of February 2014, MVP suspended its requirement for prior notification/authorization of in-network hospital admissions and professional services for normal vaginal deliveries and c-section deliveries for all products **except** MVP Option, MVP Option Family and MVP Option Child. MVP automatically covers a two-day inpatient stay for normal vaginal deliveries and a four-day inpatient stay for c-section deliveries.

Prior notification/authorization is still required for:

- Admissions or services with a non-participating provider or facility.
- Infants who are transferred to the Newborn Intensive Care Unit (NICU). This is required for all MVP products.

MVP reserves the right to reinstate such prior notification/authorization requirements for specific providers should we find unusual utilization patterns in the future.

MVP's *Provider Resource Manual* and *UM Guide* will be updated to reflect these changes.

QUALITY UPDATES

Reports to help facilitate patient care

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 that need 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 an *Emergency Room (ER) Utilization Reports.* This report provides detailed information on members who utilized the ER in the past month for care as well as the number of times the member utilized the ER in the past 12 months. This report is produced monthly and is usually available around the middle of each month.
- The *Inpatient Report* provides a list of members discharged from the hospital during the previous month. The report lists the discharging hospital, the length of stay, the diagnosis and the number of inpatient admissions over the last 12 months and a status column that identifies if a readmission occurred within the last 30 days. This report also is produced monthly and is available around the middle 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 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 receive these reports or have questions about any of the reports that you currently receive, please contact Michael Farina, Director Clinical Quality and Reporting, at **mfarina@mvphealthcare.com**.

Encourage follow-up visits for children with ADHD

As part of MVP's ongoing quality improvement activities, we encourage members on medication for ADHD to follow-up with their provider(s) to ensure they are following the prescribed regime. **Once a child starts on ADHD medication, it is recommended[1] that they:**

- Are seen **within 30 days** and that the visit occurs with a prescribing practitioner
- Are seen **two more times** in the remaining **nine months** by any health care professional

Soon, MVP will call the parents of children who recently started on an ADHD medication and encourage them to follow-up with their provider(s) in these timeframes. We recognize that caring for a child with ADHD can be challenging and offer the following to support you:

Primary Care Quality Reports

The Gaps in Care Reports help providers identify members in need of certain visits/ screenings. The ADHD HEDIS measure (Continuation Phase) will be included on these reports. This will allow providers to easily identify members who need two more visits in a nine-month period (after the first follow-up visit that occurs in the first 30 days).

Clinical Guidelines

MVP adopted the American Academy of Pediatrics *Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents* (2011 update). This guideline can be found in the Behavioral Health section of the Provider Quality Improvement Manual. Go to **www.mvphealthcare.com/providers** and click *Provider Quality Improvement Manual*, then *Behavioral Health*, then *Attention Deficit/Hyperactivity Disorder in Children and Adolescents*.

Toolkit

The National Initiative for Children's Healthcare Quality (NICHQ) has developed a toolkit specifically for ADHD. Items in the toolkit include ADHD evaluation forms and written treatment plans for the primary care clinician; the Vanderbilt Assessment scales and scoring information for parents, educators and clinicians; educational materials for parents and additional resources. After registering (free of charge), the NICHQ toolkit can be accessed at **www.nichq.org/adhd.html**.

[1]National Committee for Quality Assurance (NCQA). HEDIS 2014® Technical Specifications for Health Plans. **www.ncqa.org.**

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:

Guidelines for the Management and Treatment of HIV/AIDS

MVP continues to endorse the guideline, Primary Care Approach to the HIV-Infected Patient. This guideline can be found at **www.hivguidelines.org**. Click *Clinical Guidelines*, then *Adults*, then *Primary Care Approach to the HIV Infected Patient*. Additional AIDS guidelines relating to adults, children, adolescents and the prevention of HIV transmission during the perinatal period can be found at **www.hivguidelines.org/Content.aspx**.

Prevention and Treatment of Osteoporosis

MVP continues to endorse the recommendations from the National Osteoporosis Foundation's (NOF) Prevention and Treatment of Osteoporosis Guideline. The NOF reviewed and updated the guideline in 2013. A section titled *Vertebral Imaging* was added. The full NOF Clinician's Guide can be found at **www.nof.org**. Click on *For Healthcare Professionals* located to the right of the screen.

Practice Guidelines for the Management of End Stage Renal Disease (ESRD)

MVP adopted guidelines for End Stage Renal Disease (ESRD) based on the National Kidney Foundation's Kidney Disease Outcome Quality Initiative (NKF KDOQI™). The National Kidney Foundation has published numerous Clinical Practice Guidelines through its KDOQI process. Topics covered include Chronic Kidney Disease (CKD, Dialysis Care, and Cardiovascular Disease in Dialysis Patients). There are no recent updates to these guidelines. For all KDOQI Guidelines for Chronic Kidney Disease (CKD) Care and KDOQI Guidelines for Dialysis Care go to the National Kidney Foundation website **(www.kidney.org)**. Click on *Professionals*, then *KDOQI*, then *Guidelines and Commentaries*.

MVP Health Care 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 12247**. The recommendations will also be available in an update to the MVP *Provider Quality Improvement Manual (PQIM)*.

The current edition of the manual is located on the provider home page at **www.mvphealthcare.com/providers** under *Provider Quality Improvement Manual*.

CARING FOR OLDER ADULTS

Alternatives to high risk medications

The Centers for Medicare & Medicaid (CMS), The American Geriatrics Society and the National Committee for Quality Assurance (NCQA) caution the use of certain high-risk medications in 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.

Glyburide is considered a high risk medication by CMS and the American Geriatrics Society because it has a greater risk of prolonged hypoglycemia and therefore should be avoided in older adults. MVP is making a concentrated effort to remind clinicians of the potential risks of using glyburide in elderly patients.

The following sulfonylureas are tier 5 ($0 copay) medications for 2014:

- Glimepiride
- Glipizide, glipizide er

We ask that you review the medications your patients are taking today. If they have a prescription for glyburide or any other medication that has been identified as high risk for older adults, please consider changing to a potentially safer medication. If you would like MVP to supply a report of prescriptions that your MVP Medicare Advantage members have filled please contact Michael Farina, Director Clinical Quality and Reporting, at **mfarina@mvphealthcare.com**.

SilverSneakers® fitness program

Keep your MVP Medicare Advantage patients moving with their SilverSneakers opportunities! They can enjoy activities such as group exercise classes that focus on improving balance, flexibility endurance and range of motion. SilverSneakers is available to MVP Medicare Advantage members at no additional cost. More information is available at **www.silversneakers.com** or by calling the MVP Medicare Customer Care Center at **1-800-665-7924**.

CLAIMS UPDATES

ICD-10 update

When this issue of *Healthy Practices* went to press President Obama just signed a bill preventing cuts to Medicare physician payments. This bill includes language delaying the adoption and implementation of ICD-10 diagnostic and procedure codes for at least one year.

MVP is evaluating this new requirement and the impacts it **may** have on our ICD-10 implementation schedule. MVP will continue to monitor information as it is released on how this delay impacts you and will continue to provide updates at **www.mvphealthcare.com/providers** then *ICD-10 Updates and FAQs*.

Don't stop your ICD-10 plans

The replacement of ICD-9 with ICD-10 codes is a significant change for the health care community and while the implementation date was pushed out at least a year to no earlier than October 1, 2015, there is still much to do to prepare. MVP encourages providers to take this additional time to prepare their systems and staff for ICD-10 conversion. Our latest survey results show that:

- 68 percent of respondents started upgrading practice management, EMR or other billing systems
- 40 percent of respondents are at least 50 percent complete with system updates
- The top barriers to ICD-10 compliance are staff training and capacity, lack of knowledge, financial impacts and vendor/trading partner readiness
- 37 percent of respondents thought about or performed a financial impact assessment for the ICD-10 transition
- 64 percent of respondents reported that their physicians have not been trained on the level of detailed documentation required for ICD-10

MVP's survey is still open. If you wish to participate go to **www.surveymonkey.com/s/MVP_ICD-10**.

It is imperative to continue with your ICD-10 preparations. The planning done now will prepare you for an easy transition to ICD-10 coding.

Home Health Agency (HHA) reporting changes

Beginning with July 1, 2014 dates of service, HHAs must provide NPI and the name of the provider who certifies members for home health services. The attending provider name and identifier *Other Provider (Individual) Names and Identifiers* is required. The HHA enters the name and NPI of the physician who certified the patient's eligibility for home health services. Both the attending physician and the other physician fields should be completed even if the certifying physician is the same as the physician who signed the plan of care. For more information go to **www.cms.gov**. Click *Outreach and Education*, then *Medicare Learning*, then *MLN Matters Articles*, then *2013 MLN Matters Article* and search for MM8441 in the *Filter On* box.

Meet Centers for Medicare & Medicaid (CMS) coding guidelines

To meet CMS guidelines that all claims are correctly billed and receive payment from CMS, follow the below coding structure on claims:

- 11x inpatient hospital
- 14x op diagnostic
- 21x skilled nursing
- 85x special facility critical access hospital when rev code
- 96x professional fees,
- 97x and 98x both professional fee extensions that a value code 05 must be present and greater than or equal to the total of the covered charges for the revenue codes.

The total covered charges for the revenue codes above should be greater than zero. An edit will be added to our system to return claims that do not meet these criteria.

MEDICAL POLICY UPDATES

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

Medical policy updates effective June 1, 2014

Allergy Testing & Allergen Immunotherapy

The medical policy criteria have been updated with criteria for provocative, inhalation, ingestion challenge tests and food allergy testing indications. The exclusion list for allergy tests that are considered not medically necessary has been expanded.

Ambulatory Holter Monitor

No criteria changes have been made to the policy. There is a Medicare Variation for mobile cardiac outpatient telemetry. There is no medical management.

Cardiac Output Monitoring

There are no criteria changes to the medical policy.

Cardiac Procedures

The policy addresses Intracoronary Brachytherapy, External Counter Pulsation (ECP), Transmycardial Laser Revascularization (TMLR), and Drug Eluting Stents. No changes have been made to the criteria for these procedures. Cardiac devices for occlusion of the left atrial appendage (e.g., the Lariat snare) are not covered as they are considered experimental and investigational.

Cardiac Rehabilitation Phase II

There are no criteria changes to the medical policy.

Compression Stockings

Previously gradient compression stockings were restricted for Medicaid members. The MVP Option Products variation has been updated with the current coverage for gradient compression stockings.

Electrical Stimulation Devices & Therapies

The medical policy has been updated with criteria for transcutaneous electrical nerve stimulation (TENS) for chronic low back pain. Functional electrical stimulation exercise devices (i.e., RT300 Electrical Stimulation Bike) are not covered. An MVP Option Variation for transcutaneous electrical nerve stimulation (TENS) and functional electrical stimulation (FES) has been added to the policy. TENS and FES for MVP Option are only covered for specific ICD-9 codes listed in the medical policy.

Experimental or Investigational Procedures

A statement has been added to the Medicare Variation that "effective January 1, 2014 it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the NCD Manual".

Genetic Counseling & Testing

The general requirements for genetic counseling and genetic testing have been updated. The criteria for the various genetic tests have been updated. The colorectal cancer susceptibility testing has been expanded to include familial adenomatous polyposis (FAP) testing, MUTYH-associated polyposis testing, Lynch syndrome (LS) or (hereditary nonpolyposis colorectal cancer, (HNPCC), and microsatellite instability (MSI) testing.

Hip Surgery (Arthroscopic) for Femoroacetabular Impingement (FAI), Acetabular Labral Tears and Snapping Hip Syndrome

The medical policy title has been expanded to include acetabular labral tears and snapping hip syndrome. Criteria have been added to the policy for the treatment of acetabular labrum tears. Arthroscopic lengthening of the iliotibial band to address snapping hip syndrome is considered to be investigational and, therefore, not covered.

Home Uterine Activity Monitoring

There are no criteria changes to the medical policy. Home uterine activity monitoring is considered not medically necessary.

Implantable Cardioverter Defibrillators

The medical policy has been updated to include an additional Indication added for NYHA Class II and left bundle branch block. Subcutaneous implantable cardioverter defibrillator systems are considered experimental/investigational and, therefore, not covered.

Infertility Advanced Services

The medical policy has been updated to reflect the most recent American Society for Reproductive Medicine (ASRM) practice guidelines. Endometrial dating is not a valid method for evaluation of luteal function or luteal phase deficiency. Post coital test is not recommended for the evaluation of female infertility.

Interspinous Process Decompression Systems (IPD)

There are no criteria changes to the medical policy. Interspinous process decompression symptoms, XSTOP®, are considered investigational for all indications. Medicare and Medicaid allow coverage of the XSTOP® when criteria in the policy are met. A statement has been added under the Exclusions that "all other interspinous decompression systems are non-covered".

Light Therapy for Seasonal Affective Disorder

There are no criteria changes to the medical policy. Light therapy for seasonal affective disorder is not covered.

Lymphedema Pumps, Compression Garments, Appliances

Lymphedema pumps are covered for lymphedema associated with breast cancer and chronic venous insufficiency. The policy was updated to state that that pneumatic compression devices (E0675 and E0676) have not been proven to be effective in the treatment of certain specific conditions.

Obstructive Sleep Apnea: Devices

The medical policy has been updated to state abbreviated cardio-respiratory sleep study (PAP-Nap) and oral pressure therapy (Winx® Sleep Therapy System) as they are considered to be experimental/investigational.

Procedures for the Management of Chronic Spinal Pain

The MVP Option and MVP Option Family variation section has been updated to state that lumbar discography for chronic low back pain is not covered.

Pulmonary Rehabilitation (Respiratory PT)

There are no criteria changes to the medical policy.

Radiofrequency Neuroablation (Rhizotomy) Procedures for Chronic Pain

The title has been changed to Radiofrequency Neuroablation (Rhizotomy) for Chronic Pain. The previous title was Radiofrequency Ablation (Rhizotomy) for Chronic Pain. The policy language has been clarified that radiofrequency neuroablation is used for rhizotomy and all other applications are considered neuroablation. The policy now includes criteria for Morton's Neuroma and "Podiatrist" has been added to the list of specialists able to perform radiofrequency neuroablation. Radiofrequency neuroablation procedures including plantar fasciitis are not covered.

Rhinoplasty

There are no criteria changes to the medical policy.

Speech Therapy (Outpatient) & Cognitive Rehabilitation

Cognitive rehabilitation has been added to the title. Cognitive rehabilitation is covered for the treatment of brain injury due to trauma, stroke, aneurysm, anoxia, encephalitis, and brain tumors when criteria in the policy are met. It is not covered to improve academic work performance because it is primarily educational and training in nature and is considered to be not medically necessary. The Vermont Variation has been expanded to include cognitive therapy as medically necessary for diagnosis and treatment of Autism Spectrum Disorders.

Spinal Cord Stimulator for Intractable Pain

There are no criteria changes to the medical policy.

Vertebroplasty/Kyphoplasty

There are no criteria changes to the medical policy.

Wheelchairs (Electric) and Power Scooters

Language has been updated for the MVP Option Variation that power wheelchairs are covered if the beneficiary's ability to perform mobility related activities of daily living in the home and/or community is significantly impaired and the beneficiary is not ambulatory.

Policies reviewed and approved in 2013 for approval without changes in March and April 2014:

- Acute Inpatient Rehabilitation
- Botulinum Toxin Treatment
- Chemical Dependency
- EEG Monitoring & Anesthesia Awareness
- Epidermal Nerve Fiber Density Testing
- Immunotherapy for Recurrent Spontaneous Abortion
- Intraoperative Neurophysiological Monitoring
- Mental Health Services
- Obstructive Sleep Apnea: Diagnosis
- Obstructive Sleep Apnea: Surgical

PHARMACY UPDATES

Policy updates effective April 1, 2014

Antipsychotics for Depression

- American Psychiatric Association treatment guideline statement for MDD was updated

Arthritis-Inflammatory Biologic Drug Therapy

- Glucocorticoid dosing was removed for Rituxan
- ACR response language updated
- BASDAI measure was removed for AS
- Xeljanz was added

Breast Cancer, Select Agents NEW

- Establishes prior authorization criteria for Halaven, Kadcyla, Perjeta and Tykerb based on NCCN guidelines and Prescribing Information

Compounded (Extemporaneous) Medications

- Removed verapamil as an example of a compounded exclusion

Cox-2 Inhibitors

- Anticoagulant classes were updated

Hepatitis C Direct Acting Antivirals NEW

- Establishes prior authorization criteria for Sovaldi and Olysio

Horizant ARCHIVED

Mail Order

- Prolia and Linzess added as not available through mail order

Pain Medication

- Zohydro ER was added requiring prior authorization

Pharmacy Programs Administration

- Reconsideration language was updated
- For Medicare, ED drugs may be subject to quantity limits
- Transition citation language was changed for Medicare
- For Option, exclusion for injectable antipsychotics was removed

Vimovo ARCHIVED

Xeljanz ARCHIVED

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

- Gralise
- Migraine Agents
- Physician Prescription Eligibility
- Prescriber Treating Self or Family Members
- Qutenza
- Sabril
- Select Hypnotics
- Weight Loss Agents
- Xyrem

Formulary updates for Commercial, Option and Marketplace formularies

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

Drug Name	Indication
Actemra SQ	RA
Adempas+	PAH
Brintellix	MDD
Fetzima ER	MDD
Gazyva*	CLL
Imbruvica	Lymphoma
Olysio+	Hepatitis C
Opsumit+	PAH
Otrexup	RA, JIA
Sovaldi+	Hepatitis C
Valchlor	Lymphoma
Zorvolex	Pain

Drugs added to Formulary (Tier 1^)

abacavir/lamivudine/zidovudine ^
bromfenac ophth
dexmethylphenidate^
duloxetine^
lamivudine^
mycophenolic acid^
telmisartan

^tier 2 on Marketplace (Exchange) formulary

Drugs moved from Tier 2 to Tier 3

Cymbalta Trizivir

Drugs added to Formulary (Tier 3)

Versacloz

Drugs removed from prior authorization

Diclegis QL Sirturo
Jetrea* Osphena
Namenda XR

*Medical drug
+ Must be obtained from Accredo Specialty Pharmacy
QL=Quantity limits apply

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