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healthy practices™

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www.mvphealthcare.com

in this issue

New UM Guide *also included for you to pull out and post!*

contacting professional relations

MVP Corporate Headquarters	1-888-363-9485
Vermont	1-800-380-3530
VMC	1-800-639-3881

David W. Oliker
MVP President & Chief Executive Officer

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 2207, Schenectady, NY 12301

Radiology Program Updates

CareCore National reminders

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

Contacting CareCore National

Please use the following contact information to call CareCore National or to log in and submit/check on a prior authorization request.

Phone: **1-866-665-8341**

Web: **www.carecorenational.com**

CareCore National Online

- Your office can create an account on the CareCore National website to submit authorizations online. All you need is a valid business email address and your MVP Provider ID or NPI to register.
- If you already have a username and password for the CareCore National website, you will not need to create a new one. You will simply update your user profile by adding MVP.
- If you access the CareCore National website via another health plan's web portal, you will not be able to access MVP information. You will need to create a Username and Password to log in directly to the CareCore National website. You can then define your user profile to include MVP and any other health plans that use CareCore National.

3D rendering codes

Effective July 1, 2012, MVP will require prior authorization for the following codes:

- 76376 – 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image post processing on an independent workstation (Use 76376 in conjunction with code[s] for base imaging procedure[s])
- 76377 – Requiring image post processing on an independent workstation (Use in conjunction with code[s] for base imaging procedure[s])

3D rendering of CT, MRI, PET or other imaging procedures can be billed; however, prior authorization must be obtained for the procedure codes noted above. If you are billing the above code in conjunction with a code that does not require authorization, an authorization is still required for the 3D rendering codes.

Virtual colonoscopy update: utilization management requirements

As of April 1, 2012, health care providers are required to contact CareCore National for MRI/MRA, CAT, PET Scans and Nuclear Cardiology procedures to obtain prior authorization. The complete list of procedure codes requiring prior authorization was most recently communicated in the January/February issue of *Healthy Practices* and is available on MVP's website **(www.mvphealthcare.com)**.

Healthy Practices newsletter 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.

MVP℠ HEALTH CARE

This update will affect Virtual Colonoscopies including the following CPT® codes:

CPT CODE	DESCRIPTION
74261	Computed Tomographic (CT) Colonography, Diagnostic, including Imaging Postprocessing; without Contrast Material
74262	Computed Tomoghraphic (CT) Colonography, Diagnostic, including Image Postprocessing; with Contrast Material (s) including Non-Contrast Images, if performed
74263	Compute Tomographic (CT) Colonography, Screening, including Image Postprocessing

Effective April 1, prior authorization for these procedure codes must be submitted to CareCore National for medical necessity review.

Professional Relations Updates

Demographic information reminder

Physicians often change practice locations and phone/fax numbers. As soon as a demographic change like this occurs, please update your CAQH profile. Also, MVP maintains a policy, to which all MVP-participating health care providers must adhere, that all demographic changes be reported to MVP as soon as you are aware of the change.

To report a demographic change to MVP, please complete the *Provider Directory Listing Change Form* found at **www.mvphealthcare.com/provider/ny/forms.html**. Fax the completed form to your regional Professional Relations Representative at the appropriate fax number listed on the form.

ICD-10 news

The Department of Health and Human Services (HHS) recently announced a proposed rule that would delay, from October 1, 2013 to October 1, 2014, the compliance date for the ICD-10 diagnosis and procedure codes. MVP will keep you updated on our progress and next steps.

To keep up to date on the latest ICD-10 news from CMS, go to this website **www.cms.gov/ICD10/02b_Latest_News.asp**.

Injection Quantity Edits and Diagnosis Match

As announced in previous issues of *Healthy Practices*, MVP Health Care has upgraded its McKesson Claims Xten™ Clinical Editing software to incorporate Waste and Abuse edits.

Please be aware that as part of those changes, MVP will edit select pharmaceutical HCPCS codes for diagnosis and quantity for claims with service dates later than June 30, 2012. This change was communicated to health care providers via *FastFax* in late March. On page three, Table 1, there is a list of J-codes with the acceptable diagnosis and quantity limits. Claims for J-codes with diagnoses and/or quantities other than those listed on the next page will be denied with the code V5, unless a prior authorization is approved by MVP.

Reminder: JW modifier policy

As of January 1, 2012, the JW modifier must be used to identify unused drugs or biologicals from single-use vials or single-use packages that are appropriately discarded. This program provides payment for the amount of drug/biological discarded along with the amount administered, up to the amount of the drug or biological indicated on the vial or package label. The smallest vial or package size needed to administer the appropriate dose should be used.

This modifier must be billed on a separate line to enable payment for the amount of the discarded drug or biological. Drug wastage must be documented in the patient's medical record with the date, time, amount wasted and reason for wastage. Upon review, any discrepancy between the amount administered to the patient and the amount billed may be denied as non-rendered unless the wastage is clearly and accurately documented. The amount billed as "wasted" must not be administered to another patient or billed to either MVP or another carrier.

Drug wastage cannot be billed if none of the drug was administered (e.g. missed appointment). The JW Modifier may NOT be applied to multi-dose vials that have a long shelf life and can be given over multiple days. These are not subject to payment for discarded amounts of drug.

MVP published this policy in the *Payment Policy* section of the *Provider Resource Manual* on 12/1/11. The *Provider Resource Manual* can be found at **www.mvphealthcare.com/providers**. Log in and click on *Online Resources*.

Web Updates

Online Resources web page update

MVP has updated the *Online Resources* web page on which links to policies, presentations and communications are posted. The columns previously used to indicate whether a posted resource applied to your MVP patients whose ID number began with a letter, a number or to both groups was removed as a result of MVP's system integration. Most resources posted online apply to all MVP members. Now, any posting that pertains to a specific region within MVP's service area is marked as such.

Medical Management authorization look-up enhancement

MVP has enhanced the authorization detail available via our website. In addition to showing the authorization number, member's name, authorization dates, referring and servicing provider, you will now see the CPT code and the description that is associated with the authorization. If a CPT code is not required for the service, you will see a generic code on the authorization with a description of the service that was requested and approved. Simply log in and go to *Medical Management* to begin a search, get the answers you need and save yourself a phone call!

New benefit limit web page

MVP is always working on ways to improve our website to give health care providers the information they need to appropriately treat our members. We know that your office often needs to

Code	Description	Rule	Maximum Units
J1745	Remicade* – Refer to Arthritis, Inflammatory Biologic Drug Therapy OR Crohn's Disease & Ulcerative Colitis, Select Agents Benefit Interpretations	Will only be reimbursed when billed with the following diagnosis codes: 555.x, 556.x, 696.x, 714.xx, and 720.xx	90
J9035	Avastin	Will only be reimbursed when billed with the following diagnosis codes: 153.x, 154.x, 162.x, 189.x, and 191.x	135
J2505	Neulasta	Will only be reimbursed when billed with the following diagnosis codes: 288.xx	1
J9310	Rituxan* – Refer to the Arthritis, Inflammatory Biologic Drug Therapy Benefit Interpretation	Will only be reimbursed when billed with the following diagnosis codes: 200.xx, 202.xx, 204.xx, 446.xx, and 714.xx.	10
J9355	Herceptin	Will only be reimbursed when billed with the following diagnosis codes: 151.x, 174.x, 175.x	72
J3487	Zometa	Will only be reimbursed when billed with the following diagnosis codes: 174.x, 198.xx, 203.xx, 275.xx, 731.x, and 733.xx.	4
J2469	Aloxi	Will only be reimbursed when billed with the following diagnosis codes: 787.xx	10
J9041	Velcade	Will only be reimbursed when billed with the following diagnosis codes: 200.xx and 203.xx	31
J2323	Tysabri* – Refer to the Crohn's Disease & Ulcerative Colitis, Select Agents OR Tysabri for Multiple Sclerosis Benefit Interpretations	Will only be reimbursed when billed with the following diagnosis codes: 340 and 555.x	300
J2353	Sandostatin Depot	Will only be reimbursed when billed with the following diagnosis codes: 253.x, 259.xx, and 787.xx	30
J2778	Lucentis	Will only be reimbursed when billed with the following diagnosis codes: 362.xx	5
J0129	Orencia* – Refer to Arthritis, Inflammatory Biologic Drug Therapy Benefit Interpretation	Will only be reimbursed when billed with the following diagnosis codes: 714.xx	100
J3488	Reclast* – Refer to the Osteoporosis Medications, (Injectables) Benefit Interpretation	Will only be reimbursed when billed with the following diagnosis codes: 731.x and 733.xx	5
J2405	ondansetron	Will only be reimbursed when billed with the following diagnosis codes: 787.xx	32
J9171	Taxotere	Will only be reimbursed when billed with the following diagnosis codes: 151.x, 162.x, 174.x, 175.x, 185, 195.x.	154

†Quantity limits, when not specific to the drug package label or Benefit Interpretation, are calculated using 90kg body weight and/or 5'6" height
*Prior authorization required for all diagnoses and quantities (except Rituxan – prior authorization required for RA diagnosis)

quickly access your patient's benefits, including whether your patient has a deductible (and how much of that deductible has been met), how many physical therapy visits are covered and how many your patient has used, and if your patient has used his or her routine eyewear/eyecare benefits. MVP recently introduced the ability to check the following information, all on a single "benefit limit" web page:

- MEMBER DEDUCTIBLE – This will show the patient's individual and family deductibles, as well as the amount of the deductible remaining and when the deductible has been met.
- PHYSICAL THERAPY/OCCUPATIONAL THERAPY LIMITS – MVP members often have a specific number of physical and occupational therapy visit limits for a benefit or calendar year. You will see how many visits a patient is allowed, and how many have been used to-date.
- MEMBER OUT-OF-POCKET MAXIMUM – Some benefit plans have a lifetime or yearly out-of-pocket maximum. You will see detail on your patient's out-of-pocket maximum, including how much has been used toward that limit.
- EYEWEAR AND EYECARE – Members who have vision benefits are allowed routine care once every year or every two years. You will see your patient's last date of service for routine eyecare and eyewear. You will need to refer to the *Benefits Display* to determine if your patient's coverage includes eyewear/eyecare every one or two years to determine if your patient is eligible for covered services.

To access the new benefit limit web page for a patient, follow these steps:

- Visit **www.mvphealthcare.com/provider** and log in to your account
- Click on the gray box to go to the *Provider Snapshot* page
- On the *Provider Snapshot* page, click *Patient Inquiry*
- Enter at least two of the following member identifiers:
  - 11-digit subscriber/member ID
  - Date of birth
  - Social Security Number
- Member's last name (first two letters)
- When your patient's information is displayed, click on his or her name in the member eligibility area
- On the member profile screen, scroll down and click on your patient's medical product to go to the benefit limit page.

Note: Only benefit limits that apply to the specific patient you look up will display on the benefit limit web page. For example, if "deductible" is not shown, it indicates that your patient does not have a benefit package that includes a deductible.

Not yet registered for an online account?

Registering for an account at **www.mvphealthcare.com** allows you a fast, easy way to get information you need about your MVP patients, our policies and procedures, newsletters and much more. If your practice has Internet access, visit **www.mvphealthcare.com/provider/register.html** to set up accounts for your staff. New features are constantly in development to make your online account a valuable tool for your practice!

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

Medical policy updates effective June 1, 2012

Acute Inpatient Rehabilitation

The indications/criteria section has been updated to clarify the following criteria:

- The member is medically stable, is able to fully participate in the rehabilitation program, and had the potential for significant measurable improvement in functional status. Measurable, practical improvement in the patient's functional condition is expected to be accomplished within a predetermined and reasonable period of time; and
- A patient requires the 24-hour availability of a physician with specialized training or experience in rehabilitation, including face-to-face visits, at least three (3) days per week to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

The exclusion section has been updated to clarify the Medicare Inpatient Rehabilitation Facility (IRF) benefit.

Air Medical Transport

There are no criteria changes to the policy.

Bariatric Surgery

The policy has been updated to include criteria for Sleeve Gastrectomy for Commercial members who are not candidates for Roux-en-Y Gastric Bypass surgery.

Electromyography & Nerve Conduction Studies

Neurophysiologist has been added to the list of specialists appropriate to perform Needle Electromyography.

Extracorporeal Shock Wave Therapy

There are no criteria changes to the policy.

Ground Ambulance Services/Ambulette Services

Ambulette services are covered for MVP Option products only. Ambulette services are not covered for Commercial or Medicare products. MVP covers Ambulette service for members residing in counties where MVP is responsible for emergency transportation.

Hip & Shoulder Joint Resurfacing

The name of this policy has been changed from Metal-on-Metal Hip Resurfacing to Hip and Shoulder Joint Resurfacing. The policy now includes language for shoulder resurfacing for treatment of arthritis and degenerative joint disease. Humeral resurfacing for glenohumeral joint osteoarthritis is considered investigational.

Implantable Cardioverter Defibrillators

The policy was updated to include indications for interrogation device evaluation.

Interspinous Process Decompression Systems (IPD)

Interspinous process decompression systems are considered investigational for all indications and are not covered for Commercial members. There is a Medicare Variation as Medicare allows coverage. An MVP Option/Option Family Variation has been added allowing coverage of the X STOP® when criteria in the policy are met.

Lymphedema Pumps, Compression Garments, and Appliances

There are no criteria changes to the policy.

Mifepristone

There are no criteria changes to the policy.

Photodynamic Therapy for Malignant & Non-malignant Indications

A Medicare Variation has been added allowing coverage of actinic keratosis using the following treatment methods: cryosurgery with liquid nitrogen; curettage; excision; or photodynamic therapy.

Phototherapeutic Keratectomy/Refractive Surgery

Injury to the cornea has been added as an indication.

Prolotherapy

There are no criteria changes to the policy. Prolotherapy is considered investigational.

Prostatic Brachytherapy

An exclusion has been added that proton beam radiation therapy for prostate cancer is not superior to conventional external beam therapy and is, therefore, considered to be not medically necessary.

Proton Beam Radiation Therapy-NEW POLICY

This is a new policy. Proton Beam Radiation Therapy is covered for the following indications:

- primary therapy for melanoma of the uveal tract (iris, choroid, or ciliary body) with no evidence of metastasis or extrascleral extension and with tumors up to 24 mm in largest diameter and 14 mm in height; or
- post-operative therapy for chordoma or low-grade chondrosarcoma of the basisphenoid region or cervical spine with residual localized tumor without evidence of metastasis.

Pediatric cancers will be reviewed on a case-by-case basis.

Speech Generating Devices

The policy has been updated to state "Communication aides that do not generate synthesized or digital speech as listed in the policy are not covered."

vermont

um policy guide

MAY 1, 2012

MVP Prior Authorization Process

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

MVP Fully-Insured Plans (HMO, POS, PPO, EPO and Non-Group Indemnity)

If a procedure or service requires prior authorization:

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

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

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

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

Prescription Drugs

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

Behavioral Health Services

MVP does not accept or require referrals (paper or electronic) from PCPs for behavioral health services when care is rendered by a network practitioner. However, there is a notification requirement and either the practitioner or member must call PrimariLink at **1-800-320-5895** to register care prior to treatment. To request additional visits beyond the initial authorization, behavioral health practitioners must complete and submit an Outpatient Treatment Report (OTR) prior to using all of the initially authorized visits. OTRs are available on the PrimariLink Web site at **www.retreathealthcare.org**.

Please note that PPO plans require notification to PrimariLink. Indemnity plans do not require notification. Effective Sept. 1, 2009, call PrimariLink for Vermont-based MVP Select Care (ASO) members. The three groups are Copley Hospital, Gifford Medical Center, and Northwestern Medical Center. The name of the employer providing the coverage is on the front of the card.

Online Resources

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

In-Office Procedure and Ambulatory Surgery Lists

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

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

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

Distributed with the May/June 2012 *Healthy Practices* VT

MVP HEALTH CARE Prior Authorization Requirements

All Plan Types

Procedures/Services Requiring Prior Authorization	For Prior Authorization Contact:
• **All Elective Inpatient Admissions** • Advanced Infertility (Available per rider) • Inpatient Rehabilitation • Skilled Nursing Facilities	Fax a completed PARF to 1-800-280-7346 or call the UM Dept. at 1-800-568-0458. For MVP Select Care (ASO) members, fax a completed PARF to 1-800-280-7346 or call the Select Care UM Dept. at 1-800-229-5851. For Non-Group Indemnity and Catamount Choice members, 1-800-229-5851.
• Transplants	Call 1-866-942-7966
Medications (all IV-administered and most IM-administered) given in the office or outpatient setting that require prior authorization are listed in the Prescription Drug Formulary for Commercial members (HMO, POS, PPO, and EPO plan types). These formularies are located online at **www.mvphealthcare.com**.	For Commercial members, fax a completed form* to 1-800-376-6373. *Forms can be found at **www.mvphealthcare.com/provider**

DME & Home Care Services (HMO, EPO, TriVantage, Non-Group Indemnity, Preferred Gold HMO-POS, GoldValue HMO-PO, GoldAnywhere PPO, PPO, Vermont First and MVP Select Care-ASO Plan Types)

Services	Procedures/Services/Treatments Needed	For Prior Authorization Contact:
Durable Medical Equipment	Durable Medical Equipment (DME) can be dispensed/billed from a physician's or podiatrist's office for stabilization and to prevent further injury, without prior authorization. This is to assure safe mobility and transportation home. The DME item must be billed with the office visit.	MVP DME Unit: 1-800-452-6966; DME fax: 1-888-452-5947 Access DME Prior Authorization Code List and other DME information at **https://www.mvphealthcare.com/provider/dme.html** or **http://tinyurl.com/yas3p5o**
Home Care Services *Does not apply to MVP's Non-Group Indemnity Plan*	• Home Infusion • Occupational Therapy** • Speech Therapy** • Nursing** • Physical Therapy** • Terbutaline Therapy	MVP Home Care Unit: 1-800-777-4793, ext. 2587

Outpatient Imaging Services (HMO, POS, EPO/PPO, HealthFirst, Preferred Gold HMO-POS, GoldValue HMO-POS, GoldAnywhere PPO, MVP CompCare, Option, Vermont First, Alternet and ASO Select Care Plan Types)

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

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

Additional Services (HMO, MVP Gold, ASO/HMO, Preferred Gold HMO-POS, GoldValue HMO-POS, GoldAnywhere PPO, and ASO/HMO/POS, MVP CompCare Plan Types)

Procedures/Services Requiring Prior Authorization			For Prior Authorization Contact:
• Air Medical Transport/Air Ambulance (For non-emergency transport) • Bariatric Surgery • Blepharoplasty • Botox Injections (Office procedure only) • Brachytherapy for Breast • BRCA 1/BRCA 2 (Genetic testing for breast cancer) • Breast Implantation • Breast Reduction Surgery • Capsule Endoscopy • Cochlear Implants & Osseointegrated Devices • Continuous Glucose Monitoring • Cosmetic vs. Reconstructive Surgery • Deep Brain Stimulation • Dental Services (Accidental Injury to Sound Teeth, Outpatient Services, Prophylactic) • DME/Prosthetics/Orthotics • Endovascular Treatment for AAA and Carotid Artery Disease • ESWT for Plantar Fasciitis (MVP Gold only) • Gaucher's Disease Treatment • Genetic Testing/Chromosomal Studies	• Hereditary Angioedema • Hip Resurfacing • Hyperbaric Oxygen Therapy • Hyperhydrosis Treatment • Immunoglobulin Therapy • Implantable Cardiac Defibrillators • IMRT • Infertility (Advanced and/or Secondary), available with Rider - Including drugs (e.g., Follotropins, Menotropins) - GIFT/ZIFT are not covered • Interstim (Sacral Nerve Stimulator) • Left Ventricular Assist Device • Lumbar Laminectomy (Discectomy)* • MSLT – Multiple Sleep Latency Testing • Oncotype Testing • Oral Surgery/Orthognathic Surgery • Organ Donor • Neuropsychological Testing • Panniculectomy/Abdominoplasty • Pectus Excavatum • Penile Implants	• Percutaneous Vertebroplasty/Kyphoplasty • Photodynamic Therapy (Malignant conditions) • Rhinoplasty • Rhizotomy/Radiofrequency Ablation • Sclerotherapy • Septoplasty* • Skin Endpoint Titration • Speech Generating Devices • Spinal Fusion – Lumbosacral* • Spinal Stimulator • Stereotactic Radiosurgery (SRS) • Synagis (Injectable for RSV) • Thoracic Electrical Bioimpedance • TMD/TMJ • Treatment of Obstructive Sleep Apnea (Policies A & B) • UPPP Surgery • Video EEG Monitoring • Virtual Colonoscopy • VNUS/EVLT • Wound Vacs • Yttrium-90	Fax a completed PARF to 1-800-280-7346 or call the UM Dept. at 1-800-568-0458. For MVP Select Care (ASO) members: • Call the Select Care Member Services Dept. at 1-800-229-5851 to confirm member benefits • Fax a completed PARF to 1-800-280-7346 or call the Select Care UM Dept. at 1-800-229-5851 *Some employer groups offer more than one MVP plan, so be sure to review the member's ID card.*

PPO†, EPO, Catamount Choice and Non-Group Indemnity Plan Types, Vermont First

Procedures/Services Requiring Prior Authorization			For Prior Authorization Contact:
• **Elective Inpatient Admissions** • Advanced Infertility (Available per rider) • Air Transport • Blepharoplasty • Breast Implantation • Breast Reduction • Cochlear Implants & Osseointegrated Devices • Continuous Glucose Monitoring • Endovascular Treatment for AAA and Carotid Artery Disease • Genetic testing†	• Hip Resurfacing • Implantable Cardiac Defibrillators • Left Ventricular Assist Device • Lumbar Laminectomy (Discectomy)* • Orthognathic Surgery • Panniculectomy/Abdominoplasty • Pectus Excavatum • Penile Implants • Percutaneous Vertebroplasty/Kyphoplasty • Rhinoplasty • Rhizotomy/Radiofrequency Ablation	• Sacral Nerve Stimulator • Sclerotherapy • Septoplasty* • Spinal Fusion – Lumbosacral* • Spinal Stimulator • Surgery for Morbid Obesity • TMD/TMJ • UPPP Surgery • Varicose Vein Treatment	For PPO and EPO members, fax a completed PARF to 1-800-280-7346 or call the UM Dept. at 1-800-568-0458. For MVP Select Care (ASO) members, fax a completed PARF to 1-800-280-7346 or call the Select Care UM Dept. at 1-800-229-5851. For Non-Group Indemnity members, contact the UM Dept. at 1-800-568-0458.

IBM Plan Types

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

For members enrolled in the IBM Medicare Supplement POS plan, please follow the prior authorization instructions for MVP Select Care (ASO) members in this *UM Policy Guide*.

*Denotes when InterQual® criteria is used for the procedure.
**HHA agencies to refer to their contract or the *Provider Resource Manual* (PRM).
Criteria for these procedures may be found in MVP's *Medical Policy (Benefit Interpretation Manual)* at **www.mvphealthcare.com.**
†Applies to EPO Preferred.

Comparison of Plan Types

MVP FULLY-INSURED PLANS

Plan Type	PCP	Referral Required	Prior Auth. Required	Formulary	Reduction of Benefits for Not Notifying MVP of Inpatient Admission	Access to a National Network	Out of Network Benefits
MVP HMO	Yes	No	Yes	Yes	No	No	No
MVP PPO	No	No	Yes	Yes	For Out-of-Network Care Only	Yes	Yes
MVP PPO Select	No	No	Yes	Yes	For Out-of-Network Care Only	No	Yes
Preferred Gold HMO-POS GoldValue HMO-POS	Yes	No	Yes	Yes	No	No	No
MVP Indemnity	No	No	No	No	No	Yes	Yes
MVP EPO	No	No	Yes	Yes	No	No	No
EPO America	No	No	Yes	Yes	No	Yes	No
EPO Preferred	No	No	Yes	Yes	No	Yes	No
Non-Group Indemnity	No	No	Yes	Yes	No	Yes	Yes
Catamount Choice	No	No	Yes	Yes	No	Yes	Yes
MVP CompCare	Yes	Yes	Yes	Yes	No	No	No
Vermont First	No	No	Yes	Yes	No	No	No

MVP SELF-FUNDED (SELECT CARE-ASO) PLANS

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

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

*For MVP Option, MVP Option Child and MVP Option Family, notification of referral is required for the following services: Dermatology, Maternity Admissions, Oral Surgery and Plastic Surgery. Notification must be obtained within 14 days of the date of service. To submit a referral online, please visit **www.mvphealthcare.com/provider**. The referral form can also be downloaded and submitted to **1-888-819-2103**.

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

Transcatheter Aortic Valve Replacement-NEW POLICY

This is a new policy. Transcatheter aortic-valve replacement (TAVR) is a new procedure proposed for use in treating aortic stenosis. A bioprosthetic valve is inserted through a catheter and implanted within the diseased native aortic valve. It is a minimally invasive procedure which is an alternative to conventional open-heart surgery for aortic stenosis. There is limited evidence that transcatheter aortic-valve replacement improves health outcomes, and therefore, is considered investigational.

List of Medical Policies reviewed and approved in 2011 without changes in April 2012:

- Bone Density Study for Osteoporosis (Dexa)
- Brachytherapy for Breast Cancer
- Chemical Dependency
- Eating Disorders
- Epidermal Nerve Fiber Density Testing
- Injection Procedures for the Management of Chronic Spinal Pain
- Mental Health Services
- Methadone Maintenance
- Obstructive Sleep Apnea: Devices
- Speech Therapy (Outpatient)
- Ventricular Assist Device (Left)

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.

2012 *Provider Quality Improvement Manual* is now available

The 2012 *Provider Quality Improvement Manual* (PQIM) has been updated and is available on the provider home page of MVP's website under the Quality Programs tab, or can be found at **www.mvphealthcare.com/provider/qim/index.html.**

Provider Quality Improvement Manual (PQIM) update – clinical guidelines re-endorsed

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

Prevention and Treatment of Osteoporosis

MVP has re-endorsed the guideline for the prevention and treatment of osteoporosis. This guideline contains recommendations applicable to postmenopausal women and men age 50 and older. This has been adopted from the National Osteoporosis Foundation (NOF) Prevention and Treatment of Osteoporosis guideline. The full NOF Clinician's Guide can be found at **www.nof.org/** (click on *For Healthcare Professionals* in the upper right-hand corner of the screen). The guideline is available in the *Women's Health* section of the PQIM.

An additional resource made available for providers within the Preventive Health section of the PQIM is the World Health Organization's (WHO) Fracture Risk Assessment tool (FRAX®).

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. 2602**. 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**

Pharmacy Updates

Preferred Glucometers

Lifescan and Accu-chek glucometers and test strips are preferred on select MVP formularies. They include, but are not limited to, Active, Advantage, Aviva Plus, Compact Plus, Nano Smartview, OneTouch Ultra, OneTouch Ultra 2, OneTouch UltraMini, OneTouch UltraSmart OneTouch SureStep OneTouch Verio and OneTouch Basic. MVP encourages providers to order a preferred glucometer for our members.

Androgens and Anabolic Steroids

Effective July 1, 2012, the following products will be subject to quantity limits as listed below unless otherwise indicated. Quantities greater than those listed will require prior authorization.

Drug Name	Quantity per 30 days	Drug Name	Quantity per 30 days
AndroGel Pump/ Packets	150 grams	Methitest tabs	30 tablets
Androderm patch	30 patches	Striant buccal tab	60 tablets
Android tabs	30 tablets	Testim gel/ packets	150 grams
Androxy tabs	60 tablets	Testopel*	10 pellets
Axiron soln/pump	90 mls	Testred caps	30 capsules
Delatestryl inj	5ml	Anadrol	30 tablets
Depo-Testosterone inj	5ml	Oxandrin	60 tablets
Fortesta gel	60 grams		

**Testopel quantity limit also applies to Medicare business Refer to the MVP Option and MVP Option Family formulary for coverage for these members*

Glucose test strips

Effective July 1, 2012, glucose test strips will be subject to quantity limits of 200 strips every 30 days or 600 strips every 90 days. Quantities exceeding these limits will require prior authorization.

Lexapro, Geodon and Prometrium

Generic equivalents are now available. The brand name products will become Tier 3, non-formulary on July 1, 2012. Impacted members and providers will receive written notification.

Brand name cough and cold products

All brand name cough and cold products will require prior authorization effective July 1, 2012. MVP covers all generic prescription products. ***Note:*** cough and cold products are excluded for MVP Option and MVP Option Family members.

Policy updates

Cox-2 Inhibitor

- Familial adenomatous colorectal polyps indication was removed
- Pradaxa was added as a step therapy qualifier

Vimovo

- Language was added for MVP Option and MVP Option Family lines of business to support formulary status

Pain Medication

- Butrans will be subject to a quantity limit of four patches in 28 days. It will also be subject to step therapy edit that requires a history of a short acting opioid
- All tramadol ER products will be subject to a quantity limit based on the FDA approved labeling
- Nucynta ER will be subject to a quantity limit of 60 tablets in 30 days
- All fentanyl immediate-release products will require prior authorization and be subject to quantity limits
- Sprix will be subject to quantity limits of 5 single day spray bottles

Provenge-NEW POLICY

- Criteria includes but is not limited to prostate cancer that has metastasized to bone or soft tissue
- Disease progression following bilateral orchiectomy or after adequate hormone therapy
- Estimated life expectancy is greater than 6 months
- Policy applies to all non-Medicare lines of business

Antineoplastic Enzyme Inhibitors

- Caprelsa was added to the policy

Select Hypnotics

- Medicare variation was added

Quantity Limit

- Dose optimization language was added

Onychomycosis

- Duration of therapy was updated for itraconazole and ciclopirox

Hepatitis B Agents

- Drugs that do not require prior authorization were removed from the policy. This policy applies to Pegasys only.

Arthritis, Inflammatory Biologic Drug Therapy

- Orencia SQ was added
- Requests for JIA will be reviewed on a case-by-case basis

Compounds (Extemporaneous)-NEW POLICY

- Establishes prior authorization criteria for compounded drugs greater than $250.00
- Policy applies to all non-Medicare lines of business

Daliresp-NEW POLICY

- Criteria includes but is not limited to a diagnosis of severe COPD
- At least a 20 pack-year smoking history
- Chronic bronchitis
- 3 month trial of an inhaled corticosteroid, long-acting anticholinergic and long-acting beta-agonist
- Policy applies to all non-Medicare lines of business

Dificid-NEW POLICY

- Criteria includes failure on IDSA recommendations and a stool sample positive for c. difficile
- Policy applies to all non-Medicare lines of business.

Sylatron-NEW POLICY

- For use as monotherapy within 84 days of surgery and diagnosis of melanoma
- Policy applies to all non-Medicare lines of business

Yervoy-NEW POLICY

- Criteria includes but is not limited to diagnosis of unresectable or metastatic melanoma
- Other criteria in NCCN guidelines and/or the package label
- Policy applies to all non-Medicare lines of business

Prescribers Treating Self or Family Member

- Language referencing Rochester products was removed
- Additional statement added whereby suspect activity may be referred to MVP's Special Investigations Unit

Medicare B vs D Determination

- Drugs used as part of renal dialysis services are subject to ESRD Consolidated Billing

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

Antimalarial Drugs	Oracea/Doryx
Migraine Agents	Physician Prescription Eligibility
Qutenza	Multiple Sclerosis, Select Oral Agents
Sabril	Multiple Sclerosis, Self-injectables
Solodyn	Copayment Adjustment for Medical Necessity
Tysabri	Zyvox
Xifaxan	

The following policies were archived

Weight Loss Agents	Blood Modifiers-Excluding RBC Agents

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
Bydureon[D]	Type 2 diabetes
Edarbyclor	Hypertension
Erivedge+	Basal cell carcinoma
Erwinaze†	Acute lymphoblastic leukemia
Eylea†+	Macular degeneration
Ferriprox	Iron overload
Inlyta+	Advanced kidney cancer
Jakafi	Myelofibrosis
Jentadueto[D]	Type 2 diabetes
Kalydeco+	Cystic fibrosis
Onfi	Lennox-Gastaut (seizures)
Oxecta	Moderate to severe pain
Picato	Actinic keratosis
Rective	Anal fissures
Viread Powder	HIV-1 infection

+Must be obtained from CuraScript for non-Medicare lines of business

Generic drugs added to Formulary (Tier 1)

amlodipine/atorvastatin (generic Caduet)
atorvastatin (generic Lipitor)
carbamazepine 12 hr caps (generic Carbatrol)
eprosartan (generic Teveten)
escitalopram (Lexapro)
felbamate susp (generic Felbatol)
lamivudine tabs (generic Epivir)
lamivudine/zidovudine (generic Combivir)
levetiracetam XR (generic Keppra XR)
minocycline ER (generic Solodyn)
progesterone (Prometrium)
ziprasidone (Geodon)

Drugs removed from the Formulary*

Combivir	Epivir tablets	Lipitor
Lexapro	Geodon	Prometrium

*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)

Axiron[QL]	Edurant
Banzel suspension	Lastacaft
Complera	Viibryd
Nexiclon XR	Tradjenta (diabetic copay)
Phoslyra	Brilinta
Viramune XR	Xerese

†Drugs indicated as "medical", when provided in a physician office or outpatient facility, are a covered Medicare Part B benefit and are subject to MVP commercial policies.

[QL]Quantity limits apply

NDC requirement – correction

In the January/February version of *Healthy Practices*, MVP communicated that a valid NDC code would be required on all claims where medication was administered to an MVP member in the office or outpatient setting. MVP is still requiring this information as of 4/1/12; however we will not require this for vaccines that have been administered to MVP members. An NDC will NOT be required for Vaccine Codes in the following range 90371 – 90748.

UM Update

Updates to Claims Xten clinical editing software

MVP Health Care is upgrading its McKesson Claims Xten™ Clinical Editing software to incorporate Waste and Abuse Knowledge Pack edits. Effective May 14, 2012, MVP will edit select DME HCPCS codes for the DME items and services listed below:

- Review of claim lines submitted for **maintenance and servicing of frequently serviced items.**
- Review of claim lines submitted for **maintenance and servicing of items that are currently rented or beneficiary owned.**
- Review of claim lines submitted for **replacement and repair of items currently rented or beneficiary owned.**
- Review of claim lines submitted for a DME **rental in which payment exceeds the maximum number of rental payments permitted** (13 months for capped rentals and 10 months for inexpensive and routinely purchased items).
- Review of claim lines submitted as a **rental, when the DME item is beneficiary owned in history.**
- Review of claim lines submitted **with an ownership modifier when the same DME item has been previously paid in history.**
- Review of claim lines submitted for **C-PAP or Bi-PAP supply codes that exceeds Medicare allowable quantities.**
- Review of claim lines submitted for utilization of **insulin pump supplies that exceeds MVP's allowable quantities.**

If you have any questions, please contact MVP's DME Unit at **1-800-452-6966** or visit **www.mvphealthcare.com/provider/dme.html**.

Quality Update

Gaps in Care report

Several times during 2012, MVP will be sending out our new Gaps in Care report to primary care providers. This report will identify members who are lacking medical services such as cancer screenings, well care visits, diabetes tests or immunizations. If a member is lacking in multiple areas, that member's information will be consolidated on one row to make it easier for providers to work with members to ensure that all services are provided in a timely fashion.

We would like to provide this report to you in an electronic format (Excel) that will allow you the ability to manipulate the report to your liking. If you would like to receive this report via email or provide us with feedback on the report contact Michael Farina, Associate Director Clinical reporting at **518-388-2463** or by email at **mfarina@mvphealthcare.com**.

Government Program Updates

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; the full data on all Medicare-eligible beneficiaries will be used 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. In a separate but related announcement, CMS advised that while the compliance date for upgrading to Version 5010 standards for electronic health transactions was January 1, 2012, CMS "enforcement discretion" is in place until June 30, 2012 to give health care providers more time to adopt 5010.

Using 5010 standards will ensure that Medicare claims provide acceptable encounter data for CMS to evaluate. However, claims submitted to MVP in the gap from January 1 – June 30 may not follow 5010 standards and will, therefore, raise the risk of CMS receiving unacceptable encounter data. During this time period, MVP is manually reviewing every Medicare claim to ensure maximum acceptance of encounter data by CMS. Please be aware that claims will be denied by MVP if they need to be revised for acceptance by CMS.

Once CMS begins enforcing 5010 standards for electronic health transactions, Medicare claims will again process normally.

Medicare Part D vaccines

For Medicare members with Part D coverage, commercially available vaccines and the fees associated with the administration

are covered under the Part D pharmacy benefit (unless excluded as a Part B benefit, such as pneumococcal, rabies, and influenza vaccines). Go to the MVP Medicare Part D formulary at **www.mvphealthcare.com** to review any restrictions.

Providers have an online option for processing Medicare Part D vaccine claims electronically. This online resource helps to reduce the current challenges in providing Medicare Part D vaccines and vaccine administration reimbursement to our members. TransactRx Vaccine Manager (formerly eDispense) is an online tool to:

- Verify members' eligibility and benefits in real-time;
- Advise members of their appropriate out-of-pocket expense;
- Provide real-time reimbursement information;
- Allow electronic claims submission for vaccines covered under Part D.

Enrollment in TransactRx is available at no cost to providers. Simply complete the one-time online enrollment process at **www.enroll.transactrx.com**. For questions related to enrollment or claims processing, contact Vaccine Manager Support directly at **1-866-522-3386**. When using TransactRx Vaccine Manager to submit a Medicare Part D vaccine claim, providers will be reimbursed according to MVP Health Care's reimbursement schedule, less the member's copay.

The most common Part D vaccines such as Zostavax and Tetanus/Diptheria/ Pertussis are in MVP's No Cost Generic Tier (Tier 5) on the 2012 Part D formulary. Members enrolled in MVP's Medicare Part D program will have a $0 copay for these vaccines in 2012.

It is important to note *that if the member pays the provider out-of-pocket, the member must submit a reimbursement claim directly to Medco for the vaccine and administration fee. Members will be reimbursed the MVP negotiated rate minus their applicable copayment. Reimbursement forms are available at* **www.mvphealthcare.com**. *In addition, TransactRx cannot be used to bill the administration and cost of Medicare* **Part B** *covered vaccines (e.g. influenza vaccine, pneumococcal vaccine, or Hepatitis B vaccine for high or intermediate risk individuals).*

Medicare Part B vs Part D vaccinations

Some vaccines, and their associated administration costs, may fall under either the Part B or Part D benefit, depending on the member's situation. Providers should bill MVP under the member's Part B (medical) benefit through MVP's medical claims system when the following situations apply and the member has MVP for their medical benefit:

1) Hepatitis B – for intermediate to high risk individuals only
2) Tetanus – when incident to an injury only
3) Tetanus/Diphtheria – when incident to an injury only
4) Tetanus/Diphtheria/Pertussis – when incident to an injury only

The appropriate diagnosis code must be used in the primary billing position for the applicable vaccine. Claims that include generic diagnosis codes will deny.

Caring for Older Adults

Improving bladder control: Talking to your patients

Patients often do not mention incontinence problems with their doctors due to embarrassment and negative social impact. Additionally, many patients incorrectly assume that Urinary Incontinence (UI) symptoms are a part of the normal aging process and there is nothing that can be done to help them.

The Centers for Medicare & Medicaid Services (CMS) requires health plans to contract with a vendor to administer a Health Outcome Survey (HOS) to Medicare Advantage (MA) members. The MA members are asked if they have accidentally leaked urine, how much of a problem it is for them, and if they have received treatment. The results nationally show that the issue of urinary incontinence is not being addressed by the PCPs.

Ask questions

Because patients don't always bring up incontinence problems on their own, it's important to ask direct questions about voiding problems as part of a routine evaluation. Some questions to consider:

- When you have a strong urge, do you leak urine on the way to the bathroom?
- Do you have a problem with urine leaking from your bladder? If yes, how long?
- Do you wear pads to protect your clothes? How often do they need to be changed?
- Do you avoid going out because you are afraid of having a leakage accident?
- Are there triggering factors, such as coughing, sneezing, lifting, etc.?

Prescribe proper treatment and/or medication

There are many ways to treat urinary incontinence including bladder training, exercises, and medication. Develop a plan of care for your patient. Successful treatment of UI should be tailored to the specific type of incontinence and its cause.

For further information about urinary incontinence and treatments, use the following links from the National Institute of Health – National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK):

For men: **www.kidney.niddk.nih.gov/kudiseases/pubs/uimen/index.aspx**

For women: **www.kidney.niddk.nih.gov/kudiseases/pubs/uiwomen/index.aspx**

Consider the risks

In addition to negative social consequences and personal embarrassment, UI can cause cellulitis, pressure or decubitus ulcers, urinary tract infections, falls with fractures, sleep deprivation, withdrawal, depression, and sexual dysfunction.

Talk to your patients

As a primary care provider, you have the potential to make a huge difference to your patients' quality of life by finding a solution to incontinence problems that is both effective and compatible with each patient's individual needs.

SPECIAL NOTE ▼

Claim entry on the MVP website

MVP has maintained an online claim entry feature as a means of electronically submitting claims. Please be aware that this "web claim form" will be taken offline on June 1 because it does not meet 5010 standards. Health care providers who use this feature must begin submitting claims to MVP via another method.