HEALTHY PRACTICES™

Vermont

VOLUME 7
NUMBER 3
SEPT./OCT. 2012

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

in this issue

contacting professional relations

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

David W. Oliker
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

MVP HEALTH CARE

www.mvphealthcare.com

Healthy Practices will now be delivered to your email

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

2012 provider seminars

This year's provider seminars will be conducted via web-based presentations. Your office is invited to attend this annual event to hear about the latest information on MVP products, systems and policies. All seminars will be held during October at the following dates and times:

Thursday	October 18	12:00 – 1:30 pm
Tuesday	October 23	12:00 – 1:30 pm
Wednesday	October 31	12:00 – 1:30 pm

Register for a seminar online at **www.mvphealthcare.com/provider**. If you have any questions, please contact Gina Polchlopek at **802-264-6521**.

Radiation therapy management

To help ensure appropriate use of new technologies and also to improve patient safety, MVP Health Care will expand the list of outpatient radiation services for which prior authorization is required to include radiation therapy services (Oncology and Radiation Oncology).

New launch date

MVP originally communicated October 1 as the launch date for this initiative. Please note that the implementation date is now **October 29, 2012** (subject to all necessary regulatory approval).

Important to know

- A list of the CPT® codes that are part of this initiative is posted on the MVP website **(www.mvphealthcare.com)**. Log in to your account, visit *Online Resources* and click *Radiation Therapy CPT Code List* in the Resources section.
- If your patient begins a radiation therapy treatment plan prior to the October 29 effective date and treatment continues past that date, you must contact CareCore National to complete a treatment plan registration process. No medical necessity review will be conducted. All treatment plans for radiation therapy that begins on or after October 29, 2012, however, will be required to go through medical necessity review.
- CareCore National's phone lines will be open two weeks prior to the implementation date (Monday, October 15) for the purpose of registering treatment plans or submitting a treatment plan that will begin after October 29. If you do not register a treatment plan, any associated claims submitted after October 29 will be denied for no authorization.

Training opportunities

Radiation oncologists can participate in training webinars with CareCore National about MVP's radiation therapy program, including submitting treatment plans. Training webinars will be held on the following dates:

Wednesday	October 10	1:00 pm – 2:00 pm
Thursday	October 11	11:00 am – 12:00 pm
Tuesday	October 16	1:00 pm – 2:00 pm

Please refer to the training *FastFax* for complete details on how to register.

Advanced radiology scheduling service

MVP Health Care will expand its affiliation with CareCore National to include a concierge service to assist members with scheduling advanced radiology services (MRI, MRA, CAT and PET scans).

New launch date

MVP originally communicated October 1 as the launch date for this initiative. Please note that the implementation date is now October 29, 2012 (subject to all necessary regulatory approval).

Important to know

For physician offices to participate in this initiative, MVP will accept proof of accreditation by the Intersocietal Accreditation Committee (IAC) or the American College of Radiology (ACR).

For detailed questions and answers about this initiative, see page 9.

Update from CareCore National

As of October 1, 2012, CareCore National will expand the timeframe for reconsideration of an initial adverse determination from 14 calendar days to 45 calendar days, for all lines of business. Such requests should be made after a denial is issued but before the diagnostic imaging service or radiation therapy service is rendered.

Auditing of professional services claims

MVP Health Care has contracted with OrthoNet to assist with the ongoing review of professional services claims. The initiative entails pending two types of claims for additional review: high-dollar procedure-based surgical claims (approximately 3 percent of surgical claims will be reviewed), and professional services claims from practices that may benefit from additional consultation on coding accuracy.

New launch date

MVP originally communicated October 1 as the launch date for this initiative. Please note that the implementation date is now October 29, 2012 (subject to all necessary regulatory approval).

For detailed questions and answers about this initiative, see page 11.

Medco is now Express Scripts

Medco, MVP Health Care's Pharmacy Benefits Manager (PBM), recently merged with Express Scripts. Express Scripts will continue to provide MVP and members of our health plans with great savings, care and convenience.

Although the name of the company that manages our prescription benefit has changed from Medco to Express Scripts, our members' coverage will not change as a result of the merger. All of the Medco information on MVP member ID cards will continue to be valid. MVP will replace the Medco logo on the cards with the Express Scripts logo as members need new cards as a result of a plan change, adding or removing a dependent or any other event that triggers a new ID card to be sent.

Medco is now Express Scripts and manages the prescription benefit for MVP. Please be aware that you may continue to see the Medco name in communications from MVP and Express Scripts during the renaming process, which will take some time to complete.

MVP continues work to curb inappropriate ER use

MVP Health Care is seeing an over-use of emergency rooms for conditions that are not true emergencies, such as ear aches and urinary tract infections.

In August, MVP Health Care sent 2,400 postcards to members across our service area who visited the emergency room two or more times during the previous six months.

The postcard is part of MVP's continuing work to encourage members to talk with their doctors about the urgent appointments you offer and to make a plan with you when it comes to where they should seek medical care if you are not available. The mailing also reminds them that MVP offers a free nurse advice line that they can call or email anytime and includes a list of area urgent care centers.

MVP has a consistent track record of talking about the convenience and cost-effectiveness of urgent care in communications to members and will continue to explore new ways to promote the use of urgent care when it's appropriate.

Additional member outreach by phone

In a recent analysis of health care utilization data showing the services our members receive and in what setting, we see that members are using the Emergency Department (ED) for conditions that appear to be non-emergent and non-life threatening; and doing so during most primary care practices' operating hours (Monday – Friday, 8 am – 5 pm). MVP will be conducting telephonic outreach to members who have utilized services in the Emergency Department for non-emergent, non-life threatening conditions. MVP will assist all members who do not have a PCP and facilitate assignment of a PCP. MVP also plans to provide education regarding our dedicated 24/7 nurse advice line and our network urgent care centers.

What health care providers can do

Physicians: As trusted health care providers to our membership, please join us in taking every appropriate opportunity to direct your patients to urgent care. The *MVP Provider Resource Manual* (PRM) outlines access requirements both during and after office hours.

Hospitals: We ask that your facility take an active role in collecting a copay or coinsurance from every MVP member who visits your ED **at the time of service** to further reinforce the financial impact of using the emergency room, especially for health concerns that may be more appropriately treated at a different site of service.

Update: sleep study benefit interpretation

MVP Health Care requires that all Polysomnography (PSG)/Sleep Studies be performed in the home setting unless the medical necessity for facility-based sleep testing is authorized by MVP's Medical Director. This mandate became effective on October 1, 2011 for all Commercial products, as communicated via *FastFax* (June 27-29, 2012). Please note that as of October 1, 2012, sleep studies for Medicare members will now be subject to this sleep study benefit interpretation.

New telemedicine mandate

As of October 1, 2012, Vermont's new telemedicine mandate, H. 37, takes effect. Telemedicine means the delivery of health care services such as diagnosis, consultation or treatment through the use of **live interactive audio and video over a secure connection** that is HIPAA-compliant. Telemedicine **does not** include the use of audio-only telephone, email, or fax. Teleophthalmology or teledermatology services may be provided by store and forward means. The distant site health care provider must document the reason the services are being provided by store and forward means.

The terms of your provider contract apply to telemedicine services including the need for medical necessity. The member's deductible, copayment and coinsurance obligations remain in place. The full text of the bill is online at **www.leg.state.vt.us/docs/2012/Acts/ACT107.pdf.** If you have any questions, please call your Vermont Professional Relations Representative at **1-800-380-3530, option 4**.

HIPAA reminder about faxes

Faxes are not specifically addressed by HIPAA, but information that MVP faxes upon the request of a health care provider may contain protected health information (PHI), to which HIPAA rules apply. Please remember that fax machines should be in a secure location where non-authorized personnel cannot access faxes.

Remote cardiac monitoring reminder

MVP requires all referred services to be provided by an MVP-participating health care provider. The following Remote Cardiac Monitoring Vendors are the only vendors that MVP members may use:

- AMI Cardiac Monitoring, Inc.
- Cardiac Monitoring Services, LLC
- CardioLink Corp
- Heartcare Corporation of America
- LifeWatch, Inc.
- Philips Remote Cardiac Services
- Tolman Clinical Laboratory

Early childhood developmental disorders coverage (expansion of autism mandate)

Effective October 1, 2012, the state of Vermont will expand the Autism Mandate to cover early childhood disorders. Some of the changes that MVP will implement for all products covering members in the state of Vermont include:

- Coverage for the diagnosis and treatment of early childhood developmental disorders, including previously-mandated autism spectrum disorders for children from birth to age 21.
- Medications that are related to early childhood developmental disorders and autism are covered for members without prescription drug coverage on their plan.
- There are no limits for Physical Therapy, Occupational Therapy or Speech Therapy for any diagnosis pertaining to early childhood developmental disorders and autism. However, MVP has the right to review medical necessity for these services to determine the amount, frequency and duration of these treatments.
- Members are still subject to copayments, deductibles and coinsurance.

CREDENTIALING UPDATE

Hyperbaric Oxygen Therapy (HBOT) credentialing criteria update

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

- All Hyperbaric Medicine Centers ("facilities") providing HBOT services will be required to provide proof that they have submitted and application for accreditation no later than July 1, 2013 and must achieve accreditation by July 1, 2014.

- After July 1, 2013, facilities that have not achieved accreditation or cannot submit proof that they have applied for accreditation will no longer meet MVP criteria and will not be reimbursed for services provided to MVP members.
- The final deadline for HBOT facility accreditation has been extended to July 1, 2014.
- After July 1, 2014, facilities that have not achieved accreditation will no longer meet MVP criteria and will not be reimbursed for services provided to MVP members.

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

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

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

Facilities must:

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

Physicians must provide documented proof of the following:

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

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

UM UPDATE

Financial incentives relating to utilization management policy

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

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

Utilization management decisions are based only on appropriateness of care and the benefits provisions of the member's coverage. MVP does not specifically reward practitioners, providers, or staff, including Medical Directors and UM staff, for issuing denials of requested care.

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

QUALITY UPDATES

Provider *Quality Improvement Manual* (PQIM) update

Clinical Guidelines Re-endorsed

MVP Health Care updates its clinical guidelines at least every two years. The review process also is initiated when new scientific evidence or national standards are published.

The current edition of the MVP *Provider Quality Improvement Manual* is online at **www.mvphealthcare.com/provider/qim/index.html.** Paper copies of these recommendations are available by calling MVP's Quality Improvement (QI) department at **1-800-777-4793 ext. 12602**.

The MVP Quality Improvement Committee (QIC) recently re-approved the following enterprise-wide clinical guidelines. These recommendations will be available in an update to the MVP *Provider Quality Improvement Manual*.

Asthma

MVP Health Care, as part of its continuing Quality Improvement Program, endorses recommendations for asthma care that are a result of a collaborative effort led by the New York State Department of Health (NYSDOH). Collaborators include NYSDOH, the New York City Department of Health and Mental Hygiene, MVP Health Care and other health plans and professional organizations from across New York State.

The guideline is derived from the Third Expert Panel 3 Report (EPR3). The EPR3 Asthma guideline was developed by an expert panel commissioned by the National Asthma Education and Prevention Program (NAEPP) Coordinating Committee (CC), National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health (NIH). The NYSDOH Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma can be found on the NYSDOH website at: **www.health.ny.gov/diseases/asthma**.

In New York, MVP encourages practitioners to use the New York State Department of Health's (NYSDOH) Asthma Action plan with their patients and families. The form is available on the NYSDOH website at: **www.health.state.ny.us/diseases/asthma/brochures.htm**.

Practitioners in Vermont are encouraged to use a similar form produced by the Vermont Department of Health. For copies of the Vermont Asthma Action Plan form, contact: Vermont Department of Health Asthma Program at **1-866-331-5622**. A sample of the Vermont action plan can be found at: **http://healthvermont.gov/prevent/asthma/tools.aspx**.

In conjunction with these guidelines, MVP offers a Condition Health Management program for our members with a diagnosis of asthma. If you would like to refer one of your patients to this program, please call the Health Care Operations Department at **1-866-942-7966**. More information on this and MVP's other health programs may also be found on MVP's website: **www.mvphealthcare.com/provider/documents/CHMReferralGuide.pdf**.

Attention Deficit Disorder

MVP Health Care, as part of its continuing Quality Improvement Program, 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* located on the provider home page of the MVP website at **www.mvphealthcare.com/provider/qim/index.html**.

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**.

In addition, for our New York practitioners, ValueOptions® offers a toll-free Provider Consult Line staffed by Board Certified Psychiatrists. These psychiatrists are available for telephonic consultation regarding all aspects of mental health and substance abuse treatment for children and adults, including appropriate use of psychotropic medications. The consult line is a valuable tool in educating physicians on how to screen for and manage children with ADHD as well as answer specific questions. Physicians and specialists may contact the ValueOptions® PCP Line for consultation at **1-877-241-5575**, Monday through Friday from 8 am to 5 pm Eastern Time.

Secondary Prevention of a Cardiac Event in Patients with Atherosclerotic Cardiovascular Disease

MVP Health Care, as part of its continuing Quality Improvement Program, has adopted the American Heart Association (AHA) and the American College of Cardiology Foundation (ACCF) Guidelines, *Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease* (2011 Update). These guidelines are endorsed by the National Heart Lung Blood Institute (NHLBI) of the National Institutes of Health (NIH).

The guideline may be accessed at the American Heart Association website for professionals at **my.americanheart.org/portal/professional** under *Statements & Guidelines*. For additional support on heart health, practitioners are encouraged to visit Million Hearts™ website at **http://millionhearts.hhs.gov/index.html**. The Million Hearts™ campaign is co-led by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS), in partnership with multiple key public agencies and private organizations. The campaign seeks to prevent one million heart attacks and strokes over five years by focusing on the "ABCS" – **A**spirin for those at highest risk, **B**lood pressure control, **C**holesterol management and **S**moking cessation. In addition to information on heart health and links to related resources, the Million Hearts™ website has interactive tools for patients to determine heart health and risk of dying from heart disease, as well as tips for how they can improve.

In conjunction with these guidelines, MVP Health Care offers a Condition Case Management program for members who have recently experienced a cardiac event (Myocardial Infarction, Angioplasty and/or stent placement). If you would like to refer one of your patients to this program, please call the Health Care Operations Department at **1-866-942-7966**. More information on this and MVP's other health programs may also be found on MVP's website: **www.mvphealthcare.com/provider/documents/CHMReferralGuide.pdf**.

CLAIMS UPDATES

Clinical editing annual updates

As part of routine claims software maintenance, MVP Health Care will upgrade its clinical editing software, which identifies coding errors and other discrepancies in information submitted via claims, in December 2012.

MVP will use National Correct Coding Initiative (NCCI) edits, in addition to current claims edits. MVP will implement diagnosis-matching edits for all lines of business in accordance with the Medicare Local Coverage Determinations (LCD) for:

- **Nerve Conduction Studies & Electromyography** – (CPT® Codes: 95900, 95903, 95904, 95905, 95933, 95934, 95936, G0255, 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872)
- **Corneal Pachymetry** – (CPT Code: 76514)
- **Visual Fields Testing** – (CPT Codes: 92081, 92082, 92083)

The CPT and HCPCS codes listed above will pend for review when submitted with a diagnosis code that is not listed in the corresponding Upstate NY LCD as a code that supports medical necessity. This claims processing procedure will apply to all claims from physicians, hospitals and ambulatory surgery centers.

CARING FOR OLDER ADULTS

Preventing falls in the elderly

According to the Centers for Disease Control and Prevention (CDC)[1], approximately one in three individuals age 65 or older sustain a fall each year but fewer than half talk to their health care practitioner about it. This is an important topic of discussion with the elderly as falls can be largely prevented and hence, injuries such as hip fractures and head trauma can be reduced. There are several key actions that health care providers can take to help their elderly patients reduce the risk of falling.

- Encourage regular exercise — discuss an exercise program that focuses on increasing leg strength and balance.
- Review patients' medications for those that may cause drowsiness or dizziness as a side-effect or in combination with other medications. In the last edition of this newsletter we introduced the newly developed chart, *Medications Considered High-Risk for Older Adults*, which includes medications that should be used with caution in the elderly. Included in this list are medications that may pose additional fall risk as well as possible alternatives.
- Ensure they have their vision checked and eyewear adjusted appropriately.
- Discuss tripping/slipping hazards in the home and ways to eliminate them.

MVP offers several tools to assist practitioners in fall prevention. The MVP *Physician Quality Improvement Manual* includes helpful sheets from the CDC guide, *Preventing Falls: How to Develop Community-based Fall Prevention Programs for Older Adults*. This guide includes information on how to build an effective program, as well as useful tools:

- Fall Risk Assessment
- Sample *Medication Review Form*
- Sample *Home Fall Prevention Safety Checklist*

To access the QI Manual, visit the MVP website at **www.mvphealthcare.com/provider** and click on *Quality Improvement Manual* under *Quality Programs*. The tools mentioned in this article can be found in the *Quality Improvement in the Clinical Setting* section under *Patient Safety*. Additionally, there is a *Fall Prevention* brochure that you can give to patients, as well as the *High-Risk Medication List* mentioned above.

While some falls may be inevitable, it is important to minimize the negative consequences on the elderly by preventing and treating for osteoporosis. According to the National Osteoporosis Foundation guidelines[2]:

- Bone Mineral Density (BMD) testing is recommended for women aged 65 and older. For post-menopausal women, testing should begin between 50 and 69 if they have risk factors for the condition. BMD testing should be performed after a fracture to determine severity of the disease.
- Anyone with hip or vertebral fractures should be considered for treatment, as well as those with low bone mass according to their Dual-Energy X-ray Absorptiometry (DXA) score. FDA-approved treatments include biphosphonates, estrogens, miscellaneous hormones (e.g. calcitonin) and sex hormone combinations.
- Calcium (> 1,200 mg) and vitamin D (800 – 1,000 IU) should be taken daily by adults aged 50 and older, regardless of whether other medications to prevent or treat osteoporosis are prescribed.

[1]Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Falls among older adults: An overview.* Accessed at: **http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html** on July 24, 2012.

[2]National Osteoporosis Foundation. *Clinician's Guide to Prevention and Treatment of Osteoporosis*. Washington, DC: National Osteoporosis Foundation; 2010.

MVP's Medicare stars ratings: diabetes and hypertension medication adherence

The Centers for Medicare & Medicaid Services (CMS) uses the Star Rating System to evaluate Medicare Advantage health plans, as well as their networks of physicians and other health care providers. These star ratings (from one to five stars, with more stars indicating higher quality) impact the reimbursement that plans receive from CMS to pay for member benefits and provider services.

One of the clinical quality indicators that CMS has included in the Medicare star rating program is a diabetes treatment measure. This is defined as the number of MVP Medicare Advantage beneficiaries who have filled a prescription for both diabetes and hypertension but did ***not*** fill a prescription for an ACEI or ARB medication using their plan prescription drug benefit. For the past two years, MVP has received much lower scores on this measure (81%, or two stars) compared to national results. To reach the full five-star rating, we need to achieve an 87% compliance rate for this measure.

Per the American Diabetes Association Standards of Medical Care in Diabetes-2012, which MVP endorses, pharmacologic therapy for patients with diabetes and hypertension should be with a regimen that includes either an ACEI or an ARB. If one class is not tolerated, the other should be substituted.

We encourage you to prescribe an ACEI or an ARB for patients with diabetes and hypertension. It also is important to educate patients of the importance of taking an ACEI or ARB in conjunction with treatment for diabetes and hypertension. Please encourage members to fill their prescriptions using their MVP prescription drug benefit.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the July meeting. 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 at **www.mvphealthcare.com** and click on *Reference* in the top green toolbar. 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 Oct. 1, 2012

Breast Reconstruction Surgery

There are no changes to the policy.

Dental Care Services

Accidental Injury to Sound Natural Teeth Congenital Disease or Anomaly: The Medicare Variation has been updated to describe services that are covered in the outpatient and inpatient settings.

Dental Care Services: Complications of Dental Problems

A Medicare Variation has been added which lists the specific instances of dental coverage and describes the services that are covered in the outpatient and inpatient settings.

Dental Care Services: Facility Services

A Medicare Variation has been added which lists the specific instances of dental coverage and describes the services that are covered in the outpatient and inpatient settings.

Dental Care Services: Prophylactic Dental Extractions

A Medicare Variation has been added which lists the specific instances of dental coverage and describes the services that are covered in the outpatient and inpatient settings.

External Breast Prosthesis

The policy has been updated to state that breast prostheses with integral adhesive (L8031) have not been demonstrated to have a clinical advantage over those without the integral adhesive and are considered not medically necessary

Home Prothrombin Time Monitoring

Home prothrombin time monitoring is covered for mechanical heart valve, atrial fibrillation, and venous thromboembolism.

Immunizations/Childhood/Adolescent/Adult

Language has been updated under Indications regarding coverage of ACIP recommendations. MVP Health Care will cover immunizations recommended by the CDC when the recommendations of the ACIP are published on the CDC web site. Immunizations will be eligible for retrospective reimbursement back to the date of the ACIP meeting when the recommendation was approved.

Obstructive Sleep Apnea: Diagnosis–NEW

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

Obstructive Sleep Apnea: Diagnosis Vermont and New Hampshire–Archived

Obstructive Sleep Apnea: Diagnosis Vermont and New Hampshire medical policy has been archived.

OnDose™–NEW

Based on the review of the literature, there is insufficient evidence to support that OnDose™ improves outcomes. It is considered to be investigational and, therefore; not covered.

Oxygen & Oxygen Equipment

There are no changes to this policy.

Panniculectomy/Abdominoplasty

Panniculectomy

The policy has been updated regarding infections, intertrigo, and severe lower back pain for panniculectomy as follows:

Documentation in the member's record indicating that the panniculus hangs below the level of the pubis as demonstrated by pre-operative photographs; and

- persistent recurrent skin infections under the folds of the panniculus that remain refractory to appropriate medical treatment over a three (3) month period as documented by the member's dermatologist or primary care physician (PCP); or
- intertrigo with maceration that remains refractory to appropriate medical treatment over a three (3) month period as documented by the member's dermatologist or primary care physician (PCP); or
- severe lower back pain that is directly related to the panniculus and interferes with activities of daily living (ADLs). Documentation must indicate that the member has tried and failed a six month trial of conservative therapy including non-steroidal anti-inflammatory drugs (NSAIDS), physical therapy, and an exercise program (if appropriate).

Abdominoplasty

The policy has been updated for low back pain and conservative therapy for abdominoplasty as follows:

Documentation indicates there are structural defects of the abdominal wall (permanent overstretching) with a large or long abdominal panniculus with rectus abdominis diastasis or ventral hernia; and

Low back pain that interferes with activities of daily living due to functional incompetence of the anterior abdominal wall that has been refractive to medical treatment. Documentation must indicate that the member has tried and failed a six (6) month trial of conservative therapy including non-steroidal anti-inflammatory drugs (NSAIDS), physical therapy, and an exercise program (if appropriate).

Sclerotherapy for Varicose Veins of the Lower Extremity

The policy has been updated to state use of sclerosing solution in varicose veins ≤3mm or ≥6mm in diameter is not covered.

Stereotactic Radiosurgery – Brain

The Stereotactic Radiosurgery – Brain policy has been updated regarding the delivery of stereotactic radiosurgery as follows:

Stereotactic radiosurgery may be delivered via linac-based systems or the robotic Cyberknife system.

The criteria for stereotactic radiosurgery for the brain metastasis has been updated as follows:

- Stereotactic Radiosurgery is considered medically necessary in patients who are fully ambulatory for up to four lesions initially. Further use of SRS will be approved if the patient remains fully ambulatory and systemic disease is under control, and only if the sum of the number of lesions treated at prior episodes plus the number of lesions to be treated at the current episode are not more than seven. For more than seven lesions, only WBRT is considered medically necessary.

Therapeutic Footwear for Diabetics

The policy follows Medicare criteria. Most contracts do not allow coverage unless there is a specific foot orthotic rider.

Video EEG Monitoring

Language has been added in the Overview to clarify that inpatient admission for video EEG monitoring must meet inpatient admission criteria. The following indications for video EEG have been added to the policy:

- to characterize seizures that do not appear to be responding to treatment;
- antiepileptic drug withdrawal is needed.

List of medical policies reviewed and approved in 2011 recommended for approval without changes in July 2012:

- Continuous Passive Motion Devices
- Endovascular Procedures
- Evaluation of New Technology
- High Frequency Chest Wall Oscillation Devices
- Home Care Services
- Low Vision Aids

Please refer to the coding section on the policies to identify any code changes (e.g., new, deleted) or codes no longer requiring prior authorization for a specific policy. Each policy grid defines the prior authorization requirements for a specific product.

PHARMACY UPDATES

Generic prescribing

With the recent introduction of a multitude of first time generics to the market, a trend that is expected to continue into 2013 and beyond, the time is now to help your patients save money on their medication costs. A member's average copay for a generic medication is $6.61 and the average brand copay is $29.26. For every patient you convert to a generic drug, he/she could save over $270 per year in out-of-pocket costs. Many therapeutic classes now have *significant* generic representation. Examples include, but are not limited to, antidepressants, proton pump inhibitors, anticoagulants and antiplatelets, antihyperlipidemics, antihypertensives, antibiotics and sleep agents. As part of our ongoing cost saving initiative of decreasing our brand drug utilization by one percent, we will be contacting select prescribing providers and provide them with a list of members on brand drugs who may be candidates to switch to a generic drug in the same therapeutic class. Prescribing generic drugs also helps maintain an affordable prescription drug benefit for your MVP members.

Immunoglobulin Therapy

The preferred providers of immunoglobulin therapy are Coram Healthcare and Upstate Home Care. The Immunoglobulin Therapy prior authorization request form has been updated and can be found at **www.mvphealthcare.com/provider/ny/forms.html**.

Xarelto

The Food and Drug Administration has approved rivaroxaban:

- for prophylaxis of deep vein thrombosis which may lead to pulmonary embolism in patients undergoing knee or hip replacement surgery. The approved dosing for this indication is 10mg once daily with or without food. For patients undergoing **hip** replacement surgery, treatment duration of **35** days is recommended. For patients undergoing **knee** replacement surgery, treatment duration of **12** days is recommended.
- to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation. Dosing for this indication is 15-20mg (depending on creatinine clearance) once daily with the evening meal. The drug should be avoided in patients with CrCl <15mL/min or with moderate and severe hepatic impairment or with any degree of hepatic disease associated with coagulopathy.

The most common adverse reaction (>5%) was bleeding. A specific antidote for rivaroxaban is not available. To report suspected adverse reactions, contact Janssen Pharmaceuticals, Inc. at **1-800-526-7736** or FDA at **1-800-FDA-1088** or **www.fda.gov/medwatch**.

Policy updates

Acromegaly

- An additional example for unsuitable surgical candidates was added

Orphan Drugs and Biologicals

- Carbaglu was added

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

- Fabry's Disease
- Gaucher's Disease
- Infertility

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
Elelyso[M]	Gaucher's disease
Sorilux	Plaque psoriasis
Voraxaze[M]	Reduction in MTX levels due to impaired renal function

[D]Diabetic copay

Generic drugs added to Formulary (Tier 1)

nevirapine (Viramune)
ropinirole ext-rel (Requip XL)
tinidazole (Tindamax)

Drugs removed from the Formulary*

Activella Viramune

*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)

Xarelto

Formulary updates for Medicare members

Name of Drug	Description of Change
	Addition of drug to the formulary
clopidogrel 75mg & 300mg	(Tier 1)
doxycycline hyclate 150mg	(Tier 1)
Marlissa tabs	(Tier 1)
nevirapine 200mg tabs	(Tier 1)
ropinirole ER tb24: 2mg, 4mg, 6mg, 8mg, 12mg	(Tier 1)
Xarelto 10mg, 15mg, 20mg	(Tier 3)
escitalopram 5mg/5ml soln	(Tier 1)
fluvastatin 20mg & 40mg caps	(Tier 1)
irbesartan/HCTZ	(Tier 1)
quetiapine tabs	(Tier 1)
Ella 30mg	(Tier 3)
Latuda 20mg tabs	(Tier 3)
Potiga tabs[PA]	(Tier 3)
Uloric tabs[PA]	(Tier 3)
Zyflo 600mg tabs	(Tier 3)
Firazyr[PA]	(Tier 4)
vancomycin caps	(Tier 4)
lansoprazole caps	Increase quantity to allow 180 capsules per 90 days
pantoprazole tabs	Increase quantity to allow 180 tablets per 90 days
calcitriol ointment	No longer a Part D covered drug per CMS

QL = Quantity Limit; **PA** =Prior Authorization

Q&A: advanced radiology scheduling service

Continued from page 2

Q. What is the radiology scheduling service initiative and why is MVP doing it?

A. MVP is committed to helping members make informed choices about their health care. We will expand our relationship with CareCore National to include a concierge service to assist members of MVP-administered health plans with scheduling advanced radiology services (MRI, MRA, CAT and PET scans).

Q. How will the service work?

A. Upon clinical approval of an authorization request, CareCore National will contact patients approved for a high-tech imaging service, walk them through the process of selecting where the service will be performed and offer to connect them with the chosen site for an appointment.

- Members will receive information on quality and providers' participation with MVP (in- or out-of-network). Member requests for specific, participating facilities will be honored.
- CareCore National will send the authorization approval to the requesting provider, to the member and to MVP to support claims payment.

Q. Will CareCore National only schedule members with offices/facilities that have ACR-accredited or IAC-accredited machines?

A. Yes. Only participating "preferred" provider groups will be available in CareCore National's system.

- Since MVP's member contracts only require them to go to a participating provider, and not specifically an ACR- or IAC-accredited provider, MVP cannot prohibit members from choosing a participating provider who is not "preferred" as part of this initiative.
- If a member insists on utilizing a participating advanced imaging provider who is not "preferred", however, CareCore National will treat the provider as a non-participating provider.
- MVP will review these authorizations and the authorization and claims will be denied based on MVP's policy that advanced radiology services may not be performed in an office that does not have ACR or IAC accreditation. The member is to be held harmless from having to pay the claim in this situation.

Q. Will freestanding radiology facilities that have been seeing MVP members still be able to see MVP members when this initiative launches?

A. Yes, as long as the freestanding radiology facility meets MVP's credentialing criteria for radiology facilities and has been approved by MVP's credentialing committee.

Q. What happens if a freestanding radiology facility that has been treating MVP members does not become a credentialed facility?

A. MVP requires that freestanding radiology facilities become credentialed with MVP to see MVP members who need an advanced imaging service. If a facility is not credentialed, members will not be able to choose that facility during the scheduling process and authorizations will not be made to that freestanding facility. If a member has out-of-network benefits, they may choose to use a non-credentialed freestanding radiology facility while utilizing their out-of-network benefits.

Q. What will servicing providers need to do differently once the scheduling service is implemented?

A. Most practices already make it a habit to make sure that an authorization is in place for a procedure prior to performing it. Before setting an appointment with an MVP member, it will now be especially important to check the CareCore National website **(www.carecorenational.com)** or speak with a representative at CareCore National to verify that an authorization is in place.

Q. What if a member doesn't want to go to the imaging location at which CareCore National schedules them?

A. CareCore National will attempt to reach members by phone over the course of two days to schedule the radiology service. If that outreach is not successful, the member is auto-assigned a place of service by CareCore National. CareCore National will send a letter to the member with information about the assigned location.

- If CareCore National reaches the member by phone, member requests for specific, participating providers with ACR or IAC accreditation will be honored.
- If CareCore National auto-assigns a place of service and communicates that assignment via a letter, members may call CareCore National upon the receipt of the letter to change the location for their procedure. Member requests for specific, participating providers with ACR or IAC accreditation will be honored.

Q. What if a member does not get CareCore National's phone call for scheduling and receives the letter from CareCore National with a location assigned for their procedure AFTER they undergo the procedure somewhere else?

A. Servicing health care providers must have an authorization in place unless the service is urgent/emergent, in which case the urgent/emergent process should be followed. If an authorization is not on file and the service is performed, the claim will be denied, but the member will be held harmless (unless the member does not have out-of-network benefits and used an out-of-network provider). This is the same process that is in place today.

Q. What if a member completes the scheduling process with CareCore National but at last minute decides to go to a different site to have the procedure performed? Will the claim still be paid?

A. Servicing providers are aware they must have an authorization in place prior to seeing a member. The claim will be denied, but the member will be held harmless (unless the member does not have out-of-network benefits and used an out-of-network provider).

Q. What if a member has an emergency and needs an MRI right away?

A. For urgent/emergent cases performed in the office or outpatient setting, the health care provider must

contact CareCore National within three business days of the date that the member undergoes the procedure to get the authorization. The medical criteria for the case must be deemed medically necessary as an urgent/emergent cases to be approved. Advanced imaging performed in the emergency room and inpatient setting is not required to be reviewed by CareCore National.

Q. How long will it take for CareCore National to schedule a procedure?

A. CareCore National will attempt to reach members by phone over the course of two days to schedule the radiology service. If that outreach is not successful, the member is auto-assigned a place of service by CareCore National. CareCore National will send a letter to the member with information about the assigned location.

Q. If the service is denied, does the appeal go through CareCore National or MVP?

A. Appeals related to claims denied due to the medical necessity of an advanced radiology procedure will go through CareCore National. Appeals related to "place of service" or "no authorization on file" denials will be handled by MVP.

Q. What will change for provider offices that have performed in-office MRI/CT/PETs for MVP members in the past but are not ACR- or IAC-accredited (or do not submit proof of accreditation to MVP)?

A. MVP will align its protocol with CMS guidelines as of October 29, 2012, so that members may not receive these services from providers who are not ACR- or IAC-accredited or have not reported their accreditation to MVP by October 29; claims will not pay.

Q. If a physician office is not ACR- or IAC-accredited or does not report accreditation to MVP and claims are denied, can the member be billed?

A. No. Members are held harmless for services that are denied to providers who do not follow MVP's policy on ACR/IAC accreditation.

Q&A: auditing of professional services claims

Continued from page 2

Q. How will the initiative work?

A. Practices that are identified for this review will be individually notified by MVP that they are required to submit records for the claims that will be audited.

- These reviews will be conducted by specialty-appropriate physicians and will follow nationally-accepted coding guidelines. It is important to note that these are NOT medical necessity reviews; only the accuracy of the coding of a particular set of services will be examined.
- For any claim that is pended for additional review, OrthoNet will contact your office to request additional information, such as patient medical records or operative/clinical notes. Requested information must be submitted or the claim will be denied.

Q. Will the claim approval process take longer because of OrthoNet's audit?

A. Unless a health care provider submits records as part of the original claim submission, it is likely that claims that are reviewed by OrthoNet will take longer to process. This is because OrthoNet will request additional information from the submitting provider so that a determination can be made, so it depends on how quickly the provider office responds to the request.

Q. Will claims be identified for review by OrthoNet based on the billed or the allowed amount?

A. Claims will be identified for review based on the allowed amount.

Q. Will this impact members? If yes, how?

A. This initiative should not impact members. Members will be held harmless if a claim is denied due to OrthoNet's audit or a provider's lack of response to OrthoNet's request for additional information on a claim. Providers should not balance-bill members (If MVP pays less than what was billed by the provider, the member will not need to pay the difference).

Q. Will the member get an EOB if something is denied; if so, what will print on the EOB?

A. Yes, members will continue to be held harmless if a claim is denied as a result of OrthoNet's review. Yes, the member will get an EOB from MVP if a claim is denied with the reason: "denied pending medical records."

Q. What will happen if a health care provider does not provide the information requested by OrthoNet as part of its audit?

A. If the additional information requested by OrthoNet is not received, the claim will be denied.

Q. Will health care providers whose claims will be audited as part of this initiative be notified in advance?

A. Yes, MVP will notify the health care providers whose claims are audited, based on a listing generated by OrthoNet.

Q. As part of this program, codes originally used on claims may be changed to be more accurate or specific as a result of OrthoNet's review. Are there any legal issues if MVP change the coding on a claim?

A. No, there are no legal issues with code changes as a result of the audit by OrthoNet. Any changes will be made with the full knowledge of the provider who submitted the claim.

Q. Will members who see a non-participating provider end up having to pay the difference if the payment is reduced to that provider as a result of an audit?

A. No. If the review process reveals that a billed service was not performed, the service is not reimbursable. MVP will reimburse for the services rendered and the provider should not bill the member for anything additional.

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

your healthy practices newsletter is here!