Vermont

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

in this issue

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comments

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MVP® HEALTH CARE

www.mvphealthcare.com

MVP Health Care® debuts mobile app

MVP Health Care has launched its first mobile application ("app"). The *myMVP* mobile app allows members to use a smart phone or other mobile device to:

1. Access our *Find a Doctor* search tool to locate a health care provider or facility.
2. Display the **front and back** of their current MVP Member ID card. *(Pharmacists, please note that pharmacy info is on the back of the card.)*
3. Contact the MVP Customer Care Center.

The app is available for download from the IOS app store (Apple) and Google Play.

What MVP wants health care providers to know:

- If an MVP patient shows you an ID card on a mobile device, you should treat it the same as you would an actual "hard copy" ID card.
- Members have the ability to send you a copy of the ID card shown on their mobile device via email or fax if you require a copy of the card.
- The ID card that members can display and forward from their mobile device comes from the same system that MVP uses when we print and mail ID cards, so a member's electronic ID card will look the same as their hard copy ID card.

MVP partners with PaySpan®

MVP is excited to share that we have partnered with PaySpan to offer you, our providers, the health care industry's leading solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs) coming in 2014. This service is provided at no cost to you and allows online enrollment.

As a health care provider, the time your staff spends on payment issues and reconciliation is time taken away from patient needs. Using this free service you can take advantage of EFTs and ERAs to settle claims electronically, without making an investment in expensive EDI software. Following a quick online enrollment, you will be able to receive ERAs and import the information directly into your Practice Management or Patient Accounting System, eliminating the need to key remittance data off of paper advices.

Using this service will rapidly transition you into the world of electronic payments and automated reconciliation, greatly reducing your paper work. You will be offered a complete solution for claim payment management including routing EFTs to the bank account(s) of your choice, managing multiple payers, choosing how you want to receive remittance details, easily re-associating payments with claims and taking advantage of claim and remittance retrieval and reporting.

If you already use PaySpan for other payers you just need to add MVP to your PaySpan profile. You will keep the same username and password you currently have through PaySpan and your banking information will remain the same. Provider's not using PaySpan already will receive a letter in the coming months with specific sign up information once registration for MVP is open.

PROFESSIONAL RELATIONS UPDATES

Health Benefit Exchanges and you!

The nation's Health Benefit Exchanges open for business on October 1. These online marketplaces will make it simple for individuals and small employer groups to shop for and enroll in health plans for coverage that is effective January 1, 2014. MVP can help you and your practice navigate the new Exchange environment, starting with an information-packed online presentation that you can access anytime on the MVP website.

Please log in to your account at **www.mvphealthcare.com** and go to *Online Resources* to access these presentations:

- New York Health Benefits Exchange Overview
- Vermont Health Benefits Exchange Overview

Learn the basics of what the Exchange is and how it will work, as well as what health care providers can expect. Our Exchange experts are your trusted source for a comprehensive overview of the Exchange, presented in a way that is easy and convenient for you!

MVP will also provide more in depth education on our Exchange products and networks during the fall provider seminars. Topics covered in both include, but are not limited to, the following:

- Newly designed ID cards
- Identification of members that are enrolled in the new products
- Product benefits
- Product network
- Definition of small group and individual products
- Preauthorization criteria

MVP will communicate seminar dates and locations in the near future. Please continue to check **www.mvphealthcare.com** for further information regarding the seminar schedules and registration. If you are unable to attend the fall seminars, another, more detailed online webinar will be provided for viewing at your convenience.

Plan to attend an MVP information seminar this fall

Your practice or facility will not want to miss MVP's annual information seminars for health care providers this fall. We are in the planning stages now for this year's webinars and seminars which will focus on:

- What health care providers need to know about working with patients and MVP once individuals and small employer groups can enroll in health coverage via Health Benefit Exchanges
- What MVP is doing to prepare for ICD-10 and what your practice/facility should be doing now to ensure compliance
- Other new and exciting updates from MVP!

Fast Faxes with registration information will go out soon. Log onto **www.mvphealthcare.com** for dates/times and information on how to register.

Anesthesia time units

Effective January 1, 2014 MVP will adopt the Medicare guidelines for anesthesia time units.

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room, or an equivalent area, and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care.

Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished, the practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

For anesthesia claims, the elapsed time, in minutes, **must** be reported. Convert hours to minutes and enter the total minutes required for the procedure in Item 24G of the CMS-1500 claim form or electronic media claim equivalent.

Time units for physician and CRNA services – both personally performed and medically directed are determined by dividing the actual anesthesia time by 15 minutes or fraction thereof. Since only the actual time of a fractional unit is recognized, the

time unit is rounded to one decimal place. The table below illustrates the conversion from minutes to units used by the contractor for processing:

Minutes	Units	Minutes	Units
1-2	0.1	16-17	1.1
3	0.2	18	1.2
4-5	0.3	19-20	1.3
6	0.4	21	1.4
7-8	0.5	22-23	1.5
9	0.6	24	1.6
10-11	0.7	25-26	1.7
12	0.8	27	1.8
13-14	0.9	28-29	1.9
15	1.0	30	2.0

Refer patients to MVP's Case/ Condition Health Management Programs

For a list of MVP's case and condition health management programs that you can print for quick reference, visit **www.mvphealthcare.com/provider/documents/CHMReferralGuide.pdf**. We've included details about which patients to consider referring to each program and what information MVP may request from you to help us serve your participating patients – all in an easy-to-follow, single-page grid!

Medical Audit

MVP has been conducting select medical audits for several years, however to add efficiencies and consistencies in the processes, we have elected to consolidate these to a single unit within Health Services. Medical audits are performed to ensure providers are following MVP's clinical and coding guidelines when providing services or care. Medical auditing is a cost effective approach to review/respond to utilization trends for medical services not managed through the traditional Prospective, Concurrent, or Retrospective review processes. Medical auditing is performed on health services where MVP has elected to relax prior authorization guidelines for those targeted services and for services where MVP has chosen to perform limited post service review. Audits are performed to ensure services are provided in accordance with MVP policies, contracts and billing guidelines. Examples of services audited include, but are not limited to, implantables, home care, home infusion, select DME, coding and clinical trials.

Providers are notified in writing when select cases are sampled for an audit and are afforded 30 days to submit chart documentation for review.

Elective deliveries prior to 39 weeks gestation

Effective January 1, 2014 MVP will reduce payments for elective delivers (c-sections or induction of labor) prior to 39 weeks gestation without an acceptable medical indication. All claims submitted by **a practitioner** for obstetrical delivery procedure codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, or 59622 will require a modifier indicating the gestational age of the child at the time of birth. Failure to include one of the following modifiers will result in the claim being denied:

- U8 – Delivery prior to 39 weeks of gestation
- U9 – Deliver at 39 weeks gestation or later

All claims submitted by **a hospital** for obstetrical deliver procedure codes 73.01, 73.1, 73.4, 74.0, 74.1, 74.2, 74.4 and 74.99 will require a condition code indicating the gestational age of the child at the time of birth. Failure to include one of the following modifiers will result in the claim being denied:

- 82 – Gestation less than 39 weeks, elective c-section or induction
- 83 – Gestation 39 weeks or greater

Claims will be processed as follows:

- Modifier or condition code included on claim when acceptable diagnosis code is documented when a delivery is less than 39 weeks gestation will be reimbursed at the full contracted rate.
- Modifier or condition code included on claim when delivery occurs at 39 weeks or later without acceptable diagnosis code will be reimbursed at full contracted rate.
- Modifier or condition code included on claim indicating delivery prior to 39 weeks gestation and acceptable diagnosis code is not documented will be reimbursed at a 10 percent reduction of the contracted rate.
- No modifier or condition code included on the claim will result in the claim being denied.

Un-cashed checks?

MVP is required to turn over any un-cashed checks to the State after the check remains outstanding for a certain period of time. We are making every effort to return the funds to the rightful owners – our members, providers and vendors. Please visit **www.longlostmoney.com** to see if MVP has any un-cashed checks in your name or in the name of your business.

Healthy Practices delivered to your email

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

CARING FOR OLDER ADULTS

Talk to your patients about taking control of bladder and prostate issues

Patients often do not mention incontinence problems with their doctors due to embarrassment and negative social impact. 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.

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, medication and surgery. Develop a plan of care for your patient. For further information about urinary incontinence and treatments, visit the websites of the National Institute of Health and the National Institute of Diabetes and the Digestive and Kidney Diseases (NIDDK).

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.

MEDICAL POLICY UPDATES

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

Medical policy updates effective October 1, 2013

Artificial Intervertebral Disc Cervical and Lumbar

Lumbar and cervical artificial disc are covered when the medical policy indications and criteria are met. For Medicare products, lumbar artificial disc replacement is not covered for Medicare members over 60 years of age.

Autologous Chondrocyte Implantation (ACI)

There are no changes to the medical policy.

Breast Reduction Surgery (Reduction Mammaplasty)

There are no changes to the medical policy.

Canaloplasty and Viscocanalostomy

A Medicare Variation has been added to the policy. The Ex-PRESS™ Miniature Glaucoma Implant device, the Ahmed Glaucoma Valve, the OptiMed Glaucoma Shunt and the Baerveld Glaucoma Shunt is covered for Medicare products only. The Ex-PRESS™ Miniature Glaucoma Implant

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um policyguide vermont

SEPT. 1, 2013

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.

Radiology, scheduling and radiation therapy

MVP has delegated the UM review for all prospective review of Radiation Therapy, MRI/MRA, PET Scan, Nuclear Cardiology, and CT/CTA, and 3D rendering imaging to CareCore National, LLC in Bluffton, SC. CareCore National (CCN) utilizes evidence-based guidelines and recommendations for imaging from national and international medical societies and evidence-based medicine research centers. For more information on CCN go to **www.mvphealthcare.com/provider**, then *Online Resources* and click on *Provider Resource Manual*. To obtain an authorization please submit requests online at **www.carecorenational.com** or call **1-800-568-0458** and follow the radiology prompts.

Chiropractic services

MVP Health Care has delegated Landmark Healthcare, Inc. to manage our members' Chiropractic care. Landmark case managers, all of whom are licensed chiropractors, use nationally accepted clinical protocols as guidelines to make UM determinations. Contact Landmark's UM Department at **1-800-638-4557.**

Online resources

Visit MVP online at **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.

Samples of MVP member ID cards

Plan information, including images of ID cards, is online as part of MVP's *Provider Resource Manual* (PRM). Log in at **www.mvphealthcare.com/provider**, go to *Online Resources* and click on *Provider Resource Manual*. Select *MVP Plan Type Information* (Section 3) for details.

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 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.

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 (IV and most IM dosage forms) given in the office or outpatient setting that require prior authorization are listed here: Commercial Formulary (HMO, POS, PPO, EPO and some ASO plans) and Medicare Part D Formulary (Preferred Gold, GoldAnywhere, GoldValue, USA Care and RxCare). 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. 12587

Outpatient Imaging Services and Radiation Therapy Management (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, Nuclear Cardiology and Radiation Therapy	Care Core National has been delegated to perform imaging reviews and Radiation Therapy Management Requirement 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 and/or Radiation Therapy Management Requirement, 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	• Hereditary Angioedema • Hip Resurfacing • Hip Surgery for FAI	• Penile Implants • Percutaneous Vertebroplasty/Kyphoplasty • Photodynamic Therapy (Malignant conditions)	Fax a completed PARF to 1-800-280-7346 or call the UM Dept. at 1-800-568-0458.

- Blepharoplasty
- Botox Injections (Office procedure only)
- 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
- Gender Reassignment Surgery
- Genetic Testing/Chromosomal Studies
- 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
- Rhinoplasty
- Rhizotomy/Radiofrequency Ablation
- Sclerotherapy
- Septoplasty*
- Skin Endpoint Titration
- Sleep Studies (Facility based)
- Speech Generating Devices
- Spinal Fusion – Lumbosacral*
- Spinal Stimulator
- 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

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, 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
- Gender Reassignment Surgery
- Genetic testing†
- Hip Resurfacing
- Hip Surgery for FAI
- 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*
- Sleep Studies (Facility based)
- 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)

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*.

Call the Select Care UM Dept. at 1-800-229-5851.

*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 Preferred PPO	No	No	Yes	Yes	For Out-of-Network Care Only	Yes	Yes
Preferred Gold HMO-POS GoldValue HMO-POS	Yes	No	Yes	Yes	No	No	No
EPO Preferred	No	No	Yes	Yes	No	Yes	No
Non-Group Indemnity	No	No	Yes	No	No	Yes	Yes
MVP CompCare	Yes	Yes	Yes	Yes	No	No	No
Vermont First	No	No	Yes	Yes	No	No	No
Bridgewell	No	No	Yes	Yes	No	Yes	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	Varies by Employer Group	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	Yes	Yes
ASO-Indemnity	No	No	Varies by Employer Group	Varies by Employer Group	No	N/A	Yes
ASO-EPO	No	No	Varies by Employer Group	Varies by Employer Group	No	Yes	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.

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.

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device, the Ahmed Glaucoma Valve, the OptiMed Glaucoma Shunt, and the Baerveld Glaucoma Shunt is not covered for Commercial products.

Capsule Endoscopy

The Medicare Variation for capsule endoscopy has been removed. The indications and criteria for capsule endoscopy apply to all products.

Cryoablation of Breast Fibroadenomas

The medical policy has been updated to include indications and criteria for cryoablation of breast adenoma.

Endovascular Repair of Aortic Aneurysms and Percutaneous Transluminal Angioplasty

The policy was previously titled "Endovascular Procedures". The policy follows InterQual criteria.

Endovenous Ablation of Varicose Veins

The policy was previously titled *"Varicose Veins of the Lower Extremities - Surgical Treatment"*. "Endovenous radiofrequency ablation or endovenous laser ablation may be considered medically necessary when the procedure is performed in one visit and criteria in the policy are met" has been added to the Indications/Criteria section. Requests for repeated treatments on the same leg must be accompanied by documentation as to the medical necessity of additional treatments.

Evaluation of New Technology

There are no changes to the medical policy.

High Frequency Chest Wall Oscillation Devices

The policy follows Medicare criteria. Additional language has been added supporting treatment for patients >7 years of age.

Home Care Services

There are no changes to the medical policy.

Laser Treatment of Port Wine Stains

Language for wart treatment has been updated to state "Wart treatment and removal will be covered according to the criteria for medical necessary listed in the MVP Medical Policy for Benign Skin Lesions".

Low Vision Aids

Low vision aids are considered not medically necessary for Commercial and Medicare members. A Medicare Variation has been added. Coverage will be considered for Option members when criteria in the policy are met.

Personal Care & Consumer Directed Services

The policy was previously titled *"Personal Care Services for MVP Option"*. Language has been added under the Overview for the Consumer Directed Personal Assistant Program (CDPAP). The CDPAP services have combined personal care Level 1 and Level 2 into one benefit. Exclusions have been added that the "Member's home is a health/safety concern for the personal care aide" and "Member is non-compliant with personal care aide appointments and/or nurse assessment visits."

Umbilical Cord Blood Banking

There are no changes to the medical policy.

Policies reviewed and approved without changes in June and August 2013

- Amniotic Membrane Transplant for the Treatment of Ocular Conditions
- Audiologic Screening (OAE)
- Breast Pumps
- Dental Care Services Accidental Injury
- Dental Care Services Facility Services
- Dental Care Services Prophylactic Dental Extractions
- External Breast Prosthesis
- Heart Transplant Rejection Testing
- Home Prothrombin Time Monitoring
- Immunizations/Childhood/Adolescent/Adult
- Knee Arthroscopy
- OnDose
- Orthognathic Surgery
- Oxygen & Oxygen Equipment
- Pannieculectomy/Abdominoplasty
- Prophylactic Mastectomy/Oophorectomy
- Robotic & Computer Assisted Surgery
- Sclerotherapy for Varicose Veins of the Lower Extremities
- Sinus Surgery – Endoscopic
- Therapeutic Footwear for Diabetics
- Ventricular Reduction Surgery
- Video EEG Monitoring

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

Effective October 1, 2013

Compounded (Extemporaneous) Medications

- All compounded medications will be moved to Tier 3. Prior authorization will be required for Tier 2 plans including but not limited to Option, Option Family, Option Child and Healthy NY

Contraceptive Agents and Family Planning

- Skyla IUD was added

Enteral Therapy-New York

- Option and Option Family criteria was updated to include coverage in persons with a diagnosis of HIV infection, AIDS or HIV-related illness or other diseases or conditions. Specific criteria was included.

Gaucher's Disease

- Elelyso added to the policy

Intranasal Steroids

- Prior authorization will be required for all multi-source brand intranasal steroids. An example includes but is not limited to Flonase.

Intranasal Steroids

- Dymista, Qnasl and Zetonna were added to the policy and require prior authorization based on existing criteria

Makena (ARCHIVE)

- Policy archived due to appropriate utilixation

Migraine Agents

- Prior authorization will be required for all multi-source brand oral migraine agents. Examples include but are not limited to brand Amerge, Maxalt and Imitrex.

Osteoporosis

- Q2051 (zoledronic acid 1mg) added to the policy
- Zoledronic acid (generic Reclast) is now available and preferred over brand Reclast

Pharmacy Programs Administration

- Provider Prevails drugs categories were updated to now include atypical antipsychotics, antidepressants, anti-rejection, anti-retroviral, select endocrine (including but not limited to growth hormone, diabetic drugs and insulin and pancreatic enzymes), hematological, multiple sclerosis and anti-seizure agents effective immediately.

Samsca

- New black box warning was added. Samsca will now be limited to one 30-day fill only.Synagis (RSV)
- Statement was added that multiple births younger than one year of age do not qualify as a risk factor

Thrombopoiesis-Stimulating Proteins

- New indication and criteria for the treatment of thrombocytopenia with hepatitis C was added

Xeljanz (NEW)

- New policy that establishes prior authorization for Xeljanz, an oral agent for the treatment of moderate to severe RA

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

- Acromegaly
- Acthar
- Direct Renin Inhibitors
- Fabry's Disease
- Hereditary Angioedema
- Infertility
- Kuvan
- Lovaza
- Pradaxa

Adderall XR for Option and Option Family

Effective October 1, 2013, brand Adderall XR will be non-formulary on the MVP Option and Option Family Formulary. An approval from MVP will be required to obtain brand Adderall XR. The generic remains covered at the lowest copay tier.

Stelara

The Prescribing Information for Stelara was recently updated to allow for self-administration. Effective October 1, 2013, Stelara will be covered under the prescription drug benefit. Members will be required to obtain Stelara from Accredo, MVP's specialty pharmacy.

Effective January 1, 2014

Angiotensin Receptor Blockers

- Prior authorization will be required for all multi-source ARBs and ARB combination products. Examples include but are not limited to brands Cozaar, Avapro, Hyzaar, Avalide, Diovan HCT and Atacand/HCT.

Proton Pump Inhibitors

- Prior authorization will be required for all multi-source PPIs. Examples include but are not limited to Prilosec (Rx), Prevacid (Rx), Protonix and Zegerid.

Vytorin

Effective October 1, 2014, Vytorin will be non-formulary, Tier 3 on the Commercial, MVP Option and Option Family and Exchange (new) formularies. Impacted members will receive a notice from MVP.

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
Cystaran+	Corneal cystine accumulation
Diclegis+	Nausea & vomiting of pregnancy
Jetrea*	Vitreomacular adhesion
Kynamro	HFH
Namenda XR	Alzheimer's dementia
Osphena	Dyspareunia
Procysbi	Nephropathic cystinosis
Sirturo	Multi-drug resistant TB

Generic drugs added to Formulary (Tier 1)

entacapone (Comtan)

zolmitriptan (Zomig)

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

Ultresa

Viokace

Drugs moved from Tier 2 (formulary) to Tier 3 (non-formulary)

Yaz

*Medical drug

†Must be obtained from Accredo Specialty Pharmacy

CLAIMS UPDATES

Plan now for ICD-10

As you are aware, and as *Healthy Practices* has reported, the Centers for Medicaid & Medicare (CMS) passed a regulation that requires the replacement of ICD-9 codes with ICD-10 codes beginning October 1, 2014. Practices face a staggering number of technology requirements, including upgrading administrative transactions, e-prescribing and health information technology adoption to name a few. The replacement of ICD-9 with ICD-10 codes is a significant change for the health care community. MVP recognizes this and wants to be a resource for you. In the last issue of *Healthy Practices* there was a helpful clip and save with a list of items to begin working on. The considerable changes needed to move to ICD-10 means that practices cannot wait to begin the necessary work. In our latest survey results, 44 percent of providers haven't started or don't know if they have started working on compliance and 22 percent of providers won't be compliant or don't know if they will be compliant. It is imperative to begin now by analyzing work flow, implementing work flow changes, identifying training needs and planning your budget. This planning will prepare you for transitioning to the ICD-10 codes and meeting the October 1, 2014 compliance deadline.

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your healthy practices newsletter is here!