# HEALTHY PRACTICES™

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INFORMATION FOR MVP-PARTICIPATING HEALTH CARE PROVIDERS

New York/MVMA/TIPA


## IN THIS ISSUE



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***Healthy Practices*** is a bi-monthly publication of the MVP Health Care Corporate Affairs Department.


We welcome your comments.


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## CVS/caremark to Manage Pharmacy Benefits

MVP Health Care announced in July that we have selected **CVS/caremark** to become our Pharmacy Benefits Manager (PBM), effective January 1, 2015.

Under the agreement, CVS/caremark, the largest integrated pharmacy company in the United States, will bring enhanced pharmacy and care management benefits to members who receive their Rx coverage from MVP. MVP Rx members also will get an extra bonus with their CVS/caremark coverage—an MVP-CVS ExtraCare® Health Card that will save them 20 percent on more than 2,200 CVS/pharmacy® (CVS) brand health-related items.

CVS/caremark will provide drug coverage across all MVP product lines in both New York and Vermont, including insurance purchased on public exchanges, Medicare Advantage, Medicaid, and Child Health Plus. Except in instances where self-insured employers contract with PBMs on their own and not through MVP, CVS/caremark will cover the many MVP members who receive coverage through their employers. In addition, members of Hudson Health Plan, an MVP Health Care company, will also be covered by the agreement.

The complete press release is available at **www.mvphealthcare.com**. Select *About Us* at the bottom of the homepage and then *Press Releases.*

We will mail new Member ID cards to all members in December that are affected by the change. The new ID cards will include CVS/caremark information. If a member makes a change to their benefits for 2015, they will receive another set of Member ID cards that show their plan change(s). We will contact members by mail this fall only if they need to take action on a prescription or choice of pharmacy for January 2015.

We will share more news and details with you in upcoming issues of *Healthy Practices*.

# PROFESSIONAL RELATIONS UPDATES

## Reminder About Billing Preventive Codes

**Modifier 33**

As part of the Patient Protection and Affordable Care Act (ACA) passed in 2010, some preventive services are covered in full without any cost to the member. A full list of preventive health services covered under the ACA can be found on the MVP website at **www.mvphealthcare.com/provider/provider_reform.html**.

CMS has developed a modifier to indicate that a service is preventive under ACA. Modifier 33 should be used when the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force A or B rating, or other preventive services identified in legislative or regulatory preventive services mandates. Modifier 33 should be used in conjunction with the CPT® codes associated with the procedures identified on the MVP Preventive Health Services. Modifier 33 is not required when submitting a CPT code that MVP has described as a preventive service.

When Modifier 33 is used in conjunction with the CPT code for a preventive service on the MVP Preventive Health Services list, the member's copay, coinsurance or cost share (i.e. deductible) will be waived in accordance with the ACA guidelines. If Modifier 33 is used with a CPT code that is not on the list, regardless of the nature of the service, the member's cost share will not be waived. Reporting the preventive service with this modifier also enables MVP to track the preventive care services provided to our members so that we can accurately report back to CMS in accordance with the guidelines.

### Modifier PT

Two preventive services that are covered in full without any cost share to the member under the ACA are colonoscopy and sigmoidoscopy screenings. When MVP members receive these services, the procedure is sometimes converted from a screening to a diagnostic procedure. In these situations, a Modifier PT should be used.

Modifier PT will result in payment of the diagnostic procedure code instead of the screening colonoscopy, screening flexible sigmoidoscopy, or screening barium enema. MVP's claim processing system will respond to the modifier by waiving the member's copay, coinsurance or cost share (i.e. deductible) for all surgical services on the same date of service as the diagnostic test. Coinsurance for Medicare beneficiaries will continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

MVP payment policies in the Provider Resource Manual are updated quarterly. Our payment polices are available when you log in to your account at **www.mvphealthcare.com** and select *Online Resources*.

## MVP Payment Policies Updated Quarterly.

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## Update: Claims for Observation Stays

As of August 1, 2014, MVP removed the prior authorization/notification requirement for observation stays. Because of this, MVP has moved to uphold and administer the New York State Department of Health (NYSDOH) and Centers for Medicare & Medicaid Services (CMS) regulatory rules defining the length of an observation level of care, as well as the policy defined in the MVP Provider Resource Manual (PRM).

These regulatory agencies, along with the PRM, consistently support the denial of payment for observation that exceeds 48 hours. The basis for this is that observation allows the physician time to evaluate, treat, and determine if the patient can be discharged or needs an alternative setting (i.e. admittance to acute care, transfer to a skilled nursing facility, etc.) or denial if this is a custodial placement issue.

**Therefore, starting January 1, 2015, MVP will enforce regulatory rules, as well as contractual denials on observation claims for those lines billing greater than 48 hours for Commercial, ASO, Medicare, and Medicaid members.** These denied lines will not be open to a medical necessity review/ appeal as the expectation is that the member should have been discharged to a more appropriate level of care as defined above.

In addition, observation claims continue to remain subject to medical necessity audits which occur post-payment and according to provider contract. For efficient claims processing, providers should submit claims with hours rather than days.

Additional information can be found in the Utilization Management section in the Provider Resource Manual. If you have any questions, please contact your MVP Professional Relations Representative.

## New Remit Explanation for Medical Necessity Denials

MVP is aligning our member liability remit explanations. When a participating provider submits a claim and a retrospective review is performed, if the service is deemed not medically necessary according to the MVP medical policy and

under the terms of the MVP provider contract, the member cannot be balance billed.

MVP has created a new remit explanation to communicate this to health care providers. Effective January 1, 2015, claims for services deemed not medically necessary will be denied on the remit as *Not Medically Necessary—Member Not Liable*. This same language also will appear on the paper remit or 835 that you receive.

### MVP Implements New York State Mandated Policies

MVP has implemented new policies in Section 4 of the MVP Provider Resource Manual to align with the NYS Medicaid Contract and Department of Health Standard Clauses. The new policies include:

- **Ownership and Disclosure Requirements.** MVP participating facilities, including but not limited to, Hospitals, Free Standing Ambulatory Surgery Centers, Skilled Nursing Facilities, Dialysis Centers, Laboratories, Durable Medical Equipment Facilities, Home Health Care Facilities, Urgent Care Centers, and Federally Qualified Health Centers are required to complete and return to MVP the Ownership and Disclosure Form. To access the form, go to **www.mvphealthcare.com/provider** and select *Forms*.
- **Disclosure of Criminal Activity Policy.** MVP participating provider groups, physicians, and facilities are required to notify MVP of any criminal activity or health care-related criminal convictions that may occur among persons affiliated with the provider. In accordance with the Disclosure of Criminal Activity Policy, you must notify MVP within five days of becoming aware of the conviction/activity by completing and returning the Prior Conduct Questionnaire that is posted at **www.mvphealthcare.com/provider** under *Forms*.
- **Certification of Individuals that have been De-barred or Suspended by Federal or State Government.** MVP participating provider groups and facilities are required to monitor their employees, staff, and agents associated with the group against the following exclusionary databases on a monthly basis; the OIG Database **(http://exclusions.oig.hhs.gov)** and the System for Award Management **(www.sam.gov)**.

MVP will send an annual mailing to all provider groups and facilities requiring that you attest to monitoring staff on a monthly basis.

To access the MVP Provider Resource Manual, log in to your account at **www.mvphealthcare.com** and select *Online Resources*.

## CARING FOR OLDER ADULTS

### Talk to Patients about Bladder Control and Prostate Problems

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

MVP encourages physicians to talk about bladder control with every patient and to ask all male patients about any prostate concerns they may have. Patients need your help to develop a plan to improve the problems they may have with bladder control. Sometimes simply asking the question can open the door to an important discussion.

### Preventing Falls in the Elderly

According to the Centers for Disease Control and Prevention (CDC), approximately one in three individuals age 65 or older sustain a fall each year but fewer than half talk to their doctor about it. This is an important topic of discussion with the elderly because falls can often be prevented, reducing injuries such as hip fractures and head trauma. There are several key actions you can take to help your elderly patients reduce the risk of falling:

- Develop a plan with your patient.
- Encourage regular exercise—discuss an exercise program with your patient that focuses on increasing leg strength and balance.
- Review their medications for those that may cause drowsiness or dizziness as a side-effect or in combination with other medications. MVP has developed a *Medications Considered High-Risk for Older Adults* chart that shows which medications should be used with caution in the elderly. Included on 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

MVP has developed some tools to assist physicians and their office staff that can be utilized for the above assessments. Go to **www.mvphealthcare.com/provider**, select *Provider Quality Improvement Manual* (PQIM) in the Quality Programs section and then select *Caring for Older Adults*. In addition to assessment tools, you also will find a brochure for your patients about fall prevention and the High-Risk Medication List mentioned in this article.

### Encourage Annual Wellness Visits

Your patients who are members of an MVP Medicare Advantage health plan have coverage for an Annual Wellness Visit (AWV), a yearly office visit that focuses on preventive health. During the AWV, you will review your patient's history and risk factors for diseases, ensure that your patient's medication list is up-to-date and provide personalized health advice and counseling. The AWV also allows you to establish or update a written, personalized prevention plan. The plan will be a part of the patient's medical record and can be given to your patient to help keep them on-track. This health plan benefit creates an opportunity for an ongoing focus on prevention that can be adapted as a beneficiary's health needs change over time. Help keep your patients as healthy as possible by encouraging them to have an AWV.

To learn more about the AWV, go to **www.cms.gov** and select *Outreach and Education*, then *MLN Products*. Click the *MLN Publications* link on the left side of the page and type *Annual Wellness Visit* in the search box for a link to *Quick Reference Information: The ABCs of Providing the Annual Wellness Visit*.

## 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, 2014

- **Amniotic Membrane Transplant for the Treatment of Ocular Conditions:** there are no changes to the medical policy criteria.
- **Athletic Pubalgia Surgery NEW:** all athletic pubalgia surgery is considered investigational.
- **Bariatric Surgery:** sleeve gastrectomy has been added as an available weight loss option and considered medically necessary when criteria in the policy are met.
- **Dental Care Services Accidental Injury:** orthodontia was removed from the definition of a sound and natural tooth.
- **Dental Care Services: Prophylactic Dental Extractions:** there are no changes to the medical policy criteria.
- **External Breast Prosthesis:** replacement of nipple prostheses has been added as an indication.
- **Gender Reassignment Surgery:** a GE Variation has been added to the policy that reduction thyroid chondroplasty is covered.
- **Heart Transplant Rejection Testing:** there are no changes to the medical policy criteria.
- **Home Prothrombin Time Monitoring:** there are no changes to the medical policy criteria.
- **Immunizations/Childhood/Adolescent/Adult:** there are no changes to the medical policy criteria.
- **Magnetoencephalography:** magnetoencephalography is now considered medically necessary for the pre-surgical evaluation of individuals with intractable focal epilepsy to identify and localize area(s) of epileptiform activity when other neurological imaging studies (electroencephalography [EEG], PET or SPECT, MRI) designed to localize

a focus area are indeterminate; and must be ordered by a neurosurgeon.

- **OnDose™:** there are no changes to the medical policy criteria.
- **Opioid Substitution Therapy:** the title has been changed from Methadone Maintenance to Opioid Substitution Therapy. Language has been added under Indications/Criteria outlining the circumstances when coverage is allowed under the medical versus pharmacy benefit.
- **Oxygen and Oxygen Equipment:** there are no changes to the medical policy criteria.
- **Panniculectomy/Abdominoplasty:** there are no changes to the medical policy criteria.
- **Prophylactic Mastectomy/Oophorectomy:** there are no changes to the medical policy criteria.
- **Robotic and Computer Assisted Surgery:** there are no changes to the medical policy criteria.
- **Sacral Nerve Stimulation:** Percutaneous Nerve Stimulation has been added to the title. There have been no changes to criteria for urinary incontinence. Criteria have been added for coverage of sacral nerve stimulation for fecal incontinence.
- **Sclerotherapy for Varicose Veins of the Lower Extremities:** residual or recurrent varicose veins post endovenous ablation was added as an indication.
- **Scoliosis Bracing NEW:** this policy addresses the indications for bracing as treatment for scoliosis and the types of braces which are covered.
- **Ventricular Reduction Surgery:** there are no changes to the medical policy criteria.

**Medical Policies for approval without changes in July and August 2014**

- Artificial Intervertebral Discs, Cervical and Lumbar
- Autologous Chondrocyte Implantation (ACI)
- Breast Reduction Surgery (Reduction Mammoplasty)
- Canaloplasty and Viscocanalostomy
- Cryoablation of Breast Fibroadenomas
- Endovascular Repair of Aortic Aneurism
- Endovenous Ablation of Varicose Veins
- Evaluation of New Technology
- High Frequency Chest Wall Oscillation Devices
- Home Care Services
- Laser Treatment of Port Wine Stains
- Low Vision Aids
- Personal Care and Consumer Directed Services
- Umbilical Cord Blood Banking

# PHARMACY UPDATES

## Policy Updates Effective September 1, 2014

**Advanced Agents for Pulmonary Hypertension**

- Adempas and Opsumit added
- Duration of approval changed

**Compounded (Extemporaneous) Medications**

- Compounds containing ketamine will not be covered

**Contraceptive Agents and Family Planning ARCHIVED**

**Cystic Fibrosis**

- TOBI Podhaler added
- Duration of approval changed

**DPP4 Inhibitors**

- Alogliptan products were added to the policy

**Gaucher's Disease**

- Duration of approval changed

**Intranasal Corticosteroids**

- Nasacort AQ was removed, available OTC
- Budesonide was added

**Kuvan**

- Duration of approval changed

**Male Hypogonadism**

- Aveed added
- Non-preferred product language was clarified

**Oral Allergen Immunotherapy NEW**

- New policy establishing prior authorization criteria for Oralair, Grastek and Ragwitek

**Samsca ARCHIVED**

**Xolair**

- Criteria added for chronic idiopathic urticarial
- Duration of approval changed
- Asthma criteria updated with IgE levels

**Policies reviewed and approved without any changes to criteria**

- Cough and Cold (Brands) Inhaled Corticosteroids
- Enteral Therapy (New Hampshire)
- Enteral Therapy (New York)
- Enteral Therapy (Vermont)
- Epinephrine Auto-Injectors Hereditary Angioedema

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- Growth Hormone
- Infertility Drug Therapy
- Specialty Procurement Exception
- Synagis

## Formulary updates for Commercial, Option, and Marketplace formularies

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

| Drug Name | Indication |
|---|---|
| Cyramza | GEJ adenocarcinoma |
| Grastek | Allergen immunotherapy |
| Myalept | lipodystrophy |
| Oralair | Allergen immunotherapy |
| Orenitram ER† | PAH |
| Otezla† | Psoriatic arthritis |
| Ragwitek | Allergen immunotherapy |

### Drugs added to Formulary (Tier 1)

clonidine (Kapvay)
telmisartan-amlodipine
Xulane
risedronate 150mg^

### Drugs removed from prior authorization

Breo Ellipta
Epaned
Mirvaso
Astagraf KL
Gilotrif†
Fabior
Trokendi XR
Brisdelle
Marqibo*
Tivicay

* Medical drug
† Must be obtained from Accredo Specialty Pharmacy
^ Tier 2 on Marketplace (Exchange) formulary