HEALTHY PRACTICES

VMC

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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

Denise V. Gonick
President and CEO

Healthy Practices
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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 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**.

MVP requests your feedback: ICD-10 readiness

MVP Health Care is preparing for the transition to ICD-10 in 2014. We are interested in our participating health care providers' progress toward ICD-10, also. Please complete our short online survey about your ICD-10 readiness. Simply go to **www.mvphealthcare.com/provider** and click the ICD-10 readiness survey link on the right side of the page. Your feedback will help us implement education and outreach to help our participating providers as we all get ready for the October 2014 adoption deadline set by CMS. We appreciate your time!

PROFESSIONAL RELATIONS UPDATES

IVR service expanded for 24/7 access to claims status

In a continued effort to improve our service, MVP has implemented a fast, simple self-service capability for the health care providers who call our Customer Care Center. We have expanded the amount of automated information that providers can receive through the IVR (Interactive Voice Response) system.

Providers can now receive more detailed claims information than ever before (filtered by NPI, date of service and MVP member ID), including:

- Billed/allowed/paid amount
- Member's responsibility
- Check number and check date
- Claim status
- Common denial reason for denied claims

Self service functionality is available 24/7. With just one call you can check multiple dates of services and multiple patients for claims submitted within the last two years. When you call MVP, simply say "claims" in the main menu and then "claims status" to access this additional information. **It is important to use the specific billing provider's NPI at the start of your call.**

Updates to advanced imaging prior authorization criteria

CareCore National (CCN), the company selected by MVP to manage the utilization of advanced imaging services for our members, is updating its prior authorization criteria.

MVP is committed to providing advance notice of CCN's criteria changes, as well as an opportunity to ask questions or provide feedback about them. Please review the following points about the criteria comment and revision process.

- Upcoming criteria changes are currently posted on the CCN website at **www.carecorenational.com/benefits-management/radiology/radiology-tools-and-criteria.aspx**
  Please note that to review the criteria, you must click the MVP Health Care link that appears under the heading that says: *Health Plan Specific Radiology Criteria – Effective March 15, 2013* on the CCN web page referenced above.
- The documents show the changes that will go into effect once the comment period closes. Health care providers will always have 90 days from the date of MVP's notification *(FastFax)* during which to review and comment on criteria changes.
- You may communicate comments/feedback on the criteria changes to your MVP Professional Relations representative.
- After the comment period, CCN will post the final, effective criteria (at the CCN web address above).
- The comment period on the currently-posted criteria changes opened on April 8, 2013. These criteria will go into effect on Monday, July 8, 2013.

POPULATION HEALTH MANAGEMENT UPDATES

MVP programs accepting referrals

MVP Health Care offers dedicated population health management to members at a variety of service levels. Drawing on the combined strength of our wellness strategists, registered nurses, social workers, respiratory therapists, physicians, pharmacists and community health care providers, MVP offers a highly focused, integrated approach to management that promotes quality, cost-effective health care throughout the care continuum. MVP case managers utilize key principles within the framework of nursing case management established by the American Nursing Association and the Case Management Society of America. MVP's Condition Health Management program focuses on members with:

- Asthma
- Low back pain
- Cancer (Oncology)
- Cardiac (post-event based)
- COPD
- Diabetes
- End stage renal (Dialysis)
- Heart failure

MVP's Acute Case Management is focused on high-risk target populations. Factors considered for identifying eligible members for case management include: diagnosis, cost, utilization (emergency room and inpatient admissions) and qualitative variables (social risk, support network), as well as members' willingness to participate in case management. Case management activities also include care of members who are undergoing organ transplant, living with hemophilia or HIV or experiencing a high-risk pregnancy. Additional factors for consideration when determining member eligibility include members who are non-adherent to the plan of care and/or members who require additional guidance in navigating the health care continuum. Members who experience a critical event or diagnosis can be referred for case management services through multiple avenues. To make a referral to our Population Health Management program, call **1-800-639-3881** or email **phmreferrals@mvphealthcare.com**.

Improving depression screening and treatment

Major depression is one of the most common mental disorders in the U.S. Among the adult population, the 12-month prevalence of depression is 6.7 percent[1]. Depression often co-occurs with other conditions and is associated with decreased adherence to medical regimes. Despite effective treatments for depression, many individuals often delay seeking treatment or do not receive an adequate trial of medication or physician follow-up. According to MVP's 2012 review of medical records at primary care offices, fewer than 70 percent of the charts reviewed had evidence of depression screening. Furthermore, HEDIS 2012 results indicated only 65 percent of individuals started on an antidepressant remained on it for the initial 12 weeks and 47 percent were still on it after six months.

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression in children (ages 12 and up) and adults in the general population when adequate systems are in place to assure appropriate follow-up[2]. Although there are many easy-to-use tools for depression screening, many offices do not have a process in place that supports the primary care practitioner in doing the appropriate screening and follow-up. Systems may include:

- Designating support staff to perform the screening using standardized questions and scoring it for the clinician. The Patient Health Questionnaire (PHQ) tool is an example of a tool that is brief and easy to administer and score.
- Providing education to the patient including side effects of medications to watch for and when to notify the clinician.
- Scheduling follow-up visits and reviewing expectations with patient.
- Assisting with referrals to specialized behavioral health treatment.

[1]National Institute of Mental Health. *Major depressive disorder among adults.* Accessed April 1, 2013 at: **www.nimh.nih.gov/statistics/1MDD_ADULT**.

[2]U.S. Preventive Services Task Force. *Screening and Treatment for Major Depressive Disorder in Children and Adolescents: Recommendation Statement.* March 2009. **www.uspreventiveservicestaskforce.org/uspstf09/depression/chdeprrs**

CREDENTIALING UPDATE

Your CAQH credentialing application

All practitioners who require credentialing must complete the online Coalition for Affordable Quality Health Care (CAQH) Universal Credentialing Application®. However, MVP may not be able to process your application for any of the following reasons:

- Your CAQH application is not complete and cannot be accessed by health plans.
- The application has expired. You are required to re-attest to the information on your application every 120 days in order to keep it current.
- You have not selected MVP as an authorized health plan on your CAQH application. You may authorize health plans individually or select "global authorization", which allows access by any health care organization that in the future represents to CAQH that you are a participating provider.
- Your personal and contact information is inaccurate. Ensure that you have included all names you may have used previously.
- Your state licenses, DEA licenses (if applicable), and/or insurance are expired. Please update CAQH with new expiration dates upon renewal.
- Your Education and Training Information is incomplete or inaccurate, the training information is not entered chronologically and/or there are unexplained gaps in the training history.
- You have requested a specialty for which you have not completed an ACGME- or AOA- accredited residency and/or fellowship, as applicable.
- You have requested a physician specialty not recognized by an ABMS or AOA board.
- Your credentialing contact information is inaccurate. Including an email address and fax number helps expedite communication.
- You have provided incomplete and/or inaccurate demographic and financial information for each contracted practice location. Note: incorrect practice information may be published in health plan directories or create issues with receipt of claims payment.
- You have not listed all the hospitals at which you previously had privileges and all hospitals at which you currently maintain privileges.
- Your malpractice insurance information is not updated after changing carriers. Always fax or email a copy of your current malpractice face sheet to CAQH for inclusion with your application.
- There is an incomplete work history or unexplained work history gaps; Work history gaps of over three months must be explained on your application.
- You have not answered the all disclosure questions appropriately and/or provided inadequate explanation for any "yes" response. Incorrect responses provided to the following disclosure questions often create delays in the credentialing process:

  Disclosure Question #13: If you have any settled law suits, state license/DEA sanctions, suspension/ termination of privileges/ membership with any hospital/health plan or exclusion from any federal insurance program, these events will have been reported to the National Practitioner Data Bank (NPDB) and/or the Healthcare Integrity and Protection Data Bank (HIPDB) and you must provide a "yes" response to disclosure question #13. Failure to provide a "yes" response to question #13, if appropriate, will delay the processing of your application.

Question #19: Provide complete and accurate information on any open, settled, dismissed, or otherwise resolved malpractice cases within the last ten years. All sections of the CAQH Malpractice Claims Explanation Supplemental form must be completed in full.

For further assistance, please contact CAQH or MVP Health Care.

CAQH Help Desk:
1-888-599-1771 or **caqh.updhelp@acsgs.com**.
Representatives are available Monday–Thursday, 7am–9pm and Fridays from 7am–7pm Eastern Time

To fax supporting documentation to CAQH:
Print the FAX COVER SHEET from the Attachments Tab of your CAQH application. Include your CAQH ID Number on each attachment. Fax to: **1-866-293-0414**.

To email supporting documentation to CAQH:
Complete the EMAIL COVER SHEET from the Attachments Tab of your CAQH application. Include your CAQH ID Number on each document you scan. Email the cover sheet and documents to: **Supportingdocsupd@acsgs.com**.

MVP Credentialing Department:
1-888-363-9485, option 3
Representatives are available Monday–Friday, 8am–5pm Eastern Time

VMC Credentialing Department
1-800-639-3881

UTILIZATION MANAGEMENT UPDATES

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.

Annual review of UM clinical criteria

InterQual® criteria, published by McKesson® Health Solutions, is used in many of MVP's medical review processes to support the medical necessity of health care services. On an annual basis, MVP opens a 15-day comment period on the criteria to health care providers. MVP will send a fast fax in the coming weeks to communicate the beginning of the comment period. A copy of the InterQual criteria changes will be made available on the MVP website at **www.mvphealthcare.com/provider/ny/reference.html.** Prior to the execution of the clinical criteria, providers will be communicated the effective date by *FastFax*.

Updates to approval notification calls for UM prior authorizations

MVP is continuing to identify ways to provide better service to our members and participating health care providers. Beginning May 1, 2013, MVP will partner with ELIZA Health to implement an automated telephonic approval notification process.

Please read carefully to understand the changes that MVP is making to the approval notification process:

- On May 1, 2013, Eliza will begin making automated approval calls to providers and members. This will replace the current process of MVP manually making notification calls to members and providers. MVP will continue to complete Pharmacy Part D calls internally.
- **IMPORTANT:** To provide the best service to our members **all providers, when submitting requests for prior authorization** will need to provide their NPI number in order to obtain the details of the call. This is a change from today's process, under which MVP is requesting to verify TaxID.
- **Medicare Approvals:** Effective immediately, MVP will follow CMS regulations and will discontinue approval notification calls to providers related to services for MVP Medicare Advantage plan members. Approval notification letters will continue to be sent to your office. In addition, approval notification information will continue to be available when you log in to your account on the MVP website at **www.mvphealthcare.com**.
- **Approval Notification Letters:** There will be no changes to the approval letters issued by MVP; all information and details will continue to be delivered as they are today.

- **Authorization Information Online:** There will be no changes to the authorization information available to you when accessing your account at the MVP website **www.mvphealthcare.com**.
- Review: To ensure the best possible service, please provide complete and accurate information on all faxes coming to MVP:

-Member Full Name	-Member ID
-Member DOB	-Provider Full Name
-Provider NPI	-Provider TaxID
-Contact Name	-Contact Number (Direct Line)

There are no changes to the current process for providers within the VMC network. Prior Approval request and notification will remain the same.

CARING FOR OLDER ADULTS

Get your patients moving!

Your older adult patients have many options when it comes to physical activity!

Free SilverSneakers® Fitness Program

As MVP Medicare Advantage members, your patients have access to the SilverSneakers Fitness Program and can explore numerous options, including group exercise classes that focus on improving balance, flexibility, endurance and range of movement.

SilverSneakers is available to MVP Medicare Advantage members at no additional cost. More information is available on the SilverSneakers website **(www.silversneakers.com)** or by calling the MVP Medicare Customer Care Center at **1-800-665-7924**.

Walking is also easy and free

Walking has many benefits, especially for sedentary individuals. If you're having trouble motivating your older patients to adopt a regular physical activity routine, inform them that walking:

- Is the most effective exercise to help maintain a healthy heart
- Can help to improve memory
- Is the easiest activity to engage in, even around the living room
- Can help improve physical and mental health with a total of just 30 minutes a day

MVP's Living Well Programs

MVP also offers health and wellness programs throughout its service area. To find current listings and to register, members may visit the MVP website **(www.mvphealthcare.com)**, click on *Medicare Members*, select the county in which they live and then click on *Live Well* to find *Health Education Classes & Programs*.

Managing osteoporosis in the elderly

According to the National Osteoporosis Foundation (NOF), one in two women 50 or older will suffer an osteoporosis-related fracture in their lifetime. Despite the availability of specialized tests to detect osteoporosis and medications to prevent it, the condition remains largely under-diagnosed and under-treated.

According to MVP's 2012 HEDIS results, less than one-quarter of women 67 or older received a bone mineral density (BMD) test or prescription for a medication to treat/prevent osteoporosis within the six months following a fracture. Osteoporosis is primarily an asymptomatic condition and often is not diagnosed until after an initial fracture which can occur from very minimal trauma.

In previous issues of *Healthy Practices* we have included information about the Centers for Medicare & Medicaid Services' (CMS) expectations for the quality of care and service offered by Medicare Advantage plans and participating physicians. CMS has developed ratings to measure how MVP is working with physicians to continually achieve excellence in the quality of health care that our members receive. The CMS has set a goal for at least 67 percent of women 67 or older to receive a BMD test or a prescription for a medication to treat/prevent osteoporosis within the six months following a fracture. Currently, the results for MVP Medicare Advantage plan members (your patients) range from 14 to 21 percent.

MVP is taking several actions to increase our quality rating for this osteoporosis measure including:

- **Adopting the NOF guidelines,** *Prevention and Treatment of Osteoporosis.* Key recommendations include:
  - –BMD testing for women 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 50 and older, regardless of whether other medications to prevent or treat osteoporosis are prescribed.
- **Educating members** on osteoporosis and encouraging them to talk to their doctor about screening and treatment. MVP recently used an automated telephone service (Eliza Corporation) to reach out to the majority of its Medicare members and educate them on important health topics, including osteoporosis.

- Offering tools to assist practitioners in managing osteoporosis:
  - Several times per year, MVP sends PCPs reports for their female patients 67 and older who have sustained a fracture. The reports, based on information from claims, are intended to be informational in nature and serve as a reminder to discuss osteoporosis treatment.
  - In addition to the guidelines, the *MVP Physician Quality Improvement Manual* has a *Caring for Older Adults* section on our website that includes helpful tools for physicians and office staff to use when working with your patients: **www.mvphealthcare.com/provider/qim/caring_for_older_adults.html.** The site includes a link to the World Health Organization's Fracture Assessment tool (FRAXX) and 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, useful tools such as a *Fall Risk Assessment, Sample Medication Review Form* and a *Sample Home Fall Prevention Safety Checklist*. Other materials include:
    - Individual's Fall Risk Assessment
    - Fall Prevention Brochure
    - Medications Considered High-Risk for Older Adults
    - Personal Medication List
    - Medication Therapy Management Program
    - Well-Being Program
    - SilverSneakers® Fitness Program
    - Health Education Classes & Programs

Note: BMD testing is a covered benefit by MVP Health Care. For MVP Medicare Advantage plan members BMD testing is covered every two years. In certain circumstances of medical necessity, a BMD test may be repeated more frequently than two years. If a patient has suffered a fracture, BMD testing should be considered.

According to the National Osteoporosis Foundation (NOF), one in two women 50 or older will suffer an osteoporosis-related fracture in their lifetime. Despite the availability of specialized tests to detect osteoporosis and medications to prevent it, the condition remains largely under-diagnosed and under-treated.

QUALITY UPDATE

2013 Provider Quality Improvement Manual (PQIM) now available

The 2013 PQIM has been updated and is available on the provider home page of MVP's website under the *Quality Programs* tab, or can be found at: **www.mvphealthcare.com/provider/qim/index.html**.

PQIM Updates

Careful Antibiotic Use-Adult and Pediatric Treatment Guidelines

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

MVP Health Care continues to endorse careful antibiotic use guidelines to help address the growing problem of antibiotic resistance. The recommendations focus on preventing antibiotic resistance in adults and children and are from the Centers for Disease Control and Prevention (CDC).

The CDC adult treatment guidelines include recommendations for Non-Specific Upper Respiratory Tract Infection; Acute Pharyngitis; Acute Bacterial Rhinosinusitis and Acute Bronchitis CDC pediatric treatment guidelines include recommendations for cough/bronchitis; the common cold Rhinitis vs. sinusitis; Otitis Media; and Pharyngitis. The CDC Tools include Practice Tips and Physician Information Sheets.

To support providers in efforts to reduce inappropriate use of antibiotics, MVP makes tools available free of charge in its *Physician Quality Improvement Manual (PQIM)* on the MVP website. In addition to the guidelines, useful tools such as viral prescription pads, waiting room posters and brochures and clinical detailing letters can be found at the *CDC Careful Antibiotic Usage* link within the PQIM.

In addition, MVP recently partnered with the Vermont Department of Health and Vermont-area insurers to promote the *Get Smart About Antibiotics* campaign created by the Centers for Disease Control and Prevention (CDC). MVP's focus is on urging all of our members (regardless of whether they live in Vermont) to talk with their doctors about when an antibiotic will help their condition, or if their condition is most likely caused by a virus that cannot be treated by an antibiotic.

MVP Health Care updates its clinical guidelines at least every two years. The review process is also initiated when new scientific evidence or national standards are published. Paper copies of these recommendations are available by calling MVP's

Quality Improvement (QI) department at **1-800-777-4793 ext. 12247**. The recommendations will also be available in an update to the *MVP Provider Quality Improvement Manual*. The current edition of the manual is located on the provider home page of the MVP website at **www.mvphealthcare.com/provider/qim/index.html**.

Management of Adult Patients with Diabetes

MVP Health Care continues to endorse, and has done so since 1996, the clinical practice guideline recommendations of the American Diabetes Association (ADA) as part of its continuing Quality Improvement Program. The ADA recommendations were updated in January. A link to the recommendations is provided within our *Adult Patients with Diabetes* guideline. Recommendations include some minor changes due to new evidence released since the prior year, as well as some more significant changes to the following sections:

- Testing For Diabetes in Asymptomatic Patients
- Prevention/Delay of Type 2 Diabetes
- Diabetes Care
- Prevention and Management of Diabetes Complications
- Diabetes Care in Specific Settings

Childhood Preventive Care

MVP continues to endorse the recommendations of the American Academy of Pediatrics (AAP) for preventive pediatric health care as MVP's preventive care guideline for children. For childhood immunizations, MVP endorses the immunization schedule put forth by the Centers for Disease Control and Prevention (CDC). This schedule is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AFP), and the American College of Obstetricians and Gynecologists (ACOG).

High Blood Cholesterol Management

MVP continues to endorse the recommendations of the National Institute of Health (NIH) Cholesterol Education Program (NCEP) Detection, Evaluation and Treatment of High Blood Cholesterol in Adults. The last recommendations released were (Adult Treatment Panel III (ATP III). A link to the full ATP III report is provided on the updated guideline cover page.

Currently, the National Heart, Lung and Blood Institute (NHLBI) is reviewing the High Blood Cholesterol guideline and expects to release the new Adult Treatment Panel IV report (ATP IV) soon. At that time, MVP will review and update its guideline accordingly.

MVP offers other tools to support providers in managing high blood cholesterol. A copy of the *ATP III Guidelines At-A-Glance Quick Desk Reference* as well as other tools can be found in the PQIM under *Cardiac Care* at **www.mvphealthcare.com/provider/qim/cardiac_care.html.**

To support your care management efforts, MVP makes tools available free of charge in its Physician Quality Improvement Manual (PQIM) on the MVP website. These guideline recommendations also serve to guide MVP case and disease management program efforts. MVP has programs for diabetes and heart health. MVP Health Care updates its clinical guidelines at least every two years. The review process is also initiated when new scientific evidence or national standards are published. Paper copies of these recommendations are available by calling MVP's Quality Improvement (QI) department at **1-800-777-4793 ext. 12247**. The recommendations will also be available in an update to the *MVP Provider Quality Improvement Manual.* The current edition of the manual is located on the provider home page of the MVP website at **www.mvphealthcare.com/provider/qim**.

MEDICAL POLICY UPDATES

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

Medical policy updates effective June 1, 2013

Botulinum Toxin Treatment

The policy was updated to include the FDA-approved indication for overactive bladder in adults. The FDA indication is only for OonabotulinumtoxinA (BOTOX®).

Electrical Stimulation Devices & Therapies (NEW Policy)

The policy follows Medicare's National and Local Coverage Determination. Coverage is allowed for TENS for chronic pain when criteria in the policy are met. There is no coverage of TENS for low back pain.

Gender Reassignment Surgery (NEW Policy)

This new policy addresses the indications and criteria for gender reassignment surgery. There are Medicare, MVP Option and Vermont variations. Gender reassignment surgery is not covered for Medicare, MVP Option and Vermont products.

Hip Surgery (Arthroscopic) for Femoroacetabular Impingement (FAI)

Open or arthroscopic treatment of FAI may be medically necessary when criteria in the policy are met.

Immunotherapy for Recurrent Spontaneous Abortion

There are no changes to the policy. Immunotherapy treatment for recurrent spontaneous abortion is considered investigational and, therefore, not medically necessary.

Injection Procedures for the Management of Chronic Spinal Pain

The Indications/Criteria section for Paravertebral Facet Joint/Nerve Block – Diagnostic and Therapeutic for both lumbar and sacral facet blocks and cervical and thoracic facet blocks has been updated. Indications for sacroiliac joint injections – diagnostic and therapeutic have been added to the policy. There is an MVP Option variation which states that there is no coverage of therapeutic facet joint injections in the lumbar and sacral regions. There is a Medicare Variation that allows coverage of facet blocks for the cervical, thoracic or sacral spine when criteria in the policy have been met.

Intraoperative Neurophysiologic Monitoring:

- The following indications have been clarified to read: "scoliosis correction with rod implantation and multi-level decompression decompressive procedures where there is evidence of myelopathy or cauda equina syndrome."
- Anterior and posterior cervical spine surgeries has been added as an indication.
- Intraoperative neurophysiological monitoring during routine, non-complicated, cervical and lumbar root decompression procedures or fusion is considered not medically necessary.

Neuropsychological Testing

The policy has been updated under the Vermont Variation to include changes in the VT mandate that the age requirement to assess and diagnose early childhood developmental disorders for children beginning from birth and continuing until the child reaches the age of 21. Services that are considered primarily educational or training in nature are considered to be not medically necessary.

Obstructive Sleep Apnea: Devices

The policy follows Medicare criteria for CPAP/BPAP/APAP. A statement has been added under Indications that members must undergo APAP titration unless APAP titration is not appropriate (Refer to the Obstructive Sleep Apnea Diagnosis medical policy).

Obstructive Sleep Apnea: Diagnosis

Criteria have been added for auto-titration positive airway pressure (APAP) titration. Members must undergo auto-titration positive airway pressure (APAP) titration unless APAP is not appropriate. The policy also outlines those conditions not appropriate for APAP.

Ventricular Assist Device (Left)

There are no changes to the indications and criteria for left ventricular assist devices. The policy has been updated with language regarding MVP Ventricular Assist Device (VAD) facilities credentialing criteria.

Vertebroplasty/Kyphoplasty

The medical policy has been updated as follows:

- Documentation requirements for osteoporotic vertebral compression fractures have been added to the medical policy.
- Percutaneous sacroplasty has not been proven in peer-reviewed literature to improve patient outcomes and is considered to be investigational.
- There is a Medicare Variation.

The following policies were reviewed and approved without any changes:

- Canaloplasty and Viscocanalostomy
- Capsule Endoscopy
- Chemical Dependency
- Eating Disorders
- EEG Monitoring & Anesthesia Awareness
- Epidermal Nerve Fiber Density Testing
- Mental Health Services
- Methadone Maintenance
- Obstructive Sleep Apnea: Surgical Treatment
- Oncotype DX Testing for Breast Cancer
- Tumor Markers (OVA 1)

Medical policies reviewed and approved in 2012 recommended for approval without changes in March and April 2013:

- Acute Inpatient Rehabilitation
- Allergy Testing & Allergen Immunotherapy
- Alopecia/Wigs/Scalp Prosthesis
- Blepharoplasty/Browlift/Ptosis Repair
- Breast Implantation
- Breast Surgery for Gynecomastia
- Electromyography & Nerve Conduction Studies
- Erectile Dysfunction
- Extracorporeal Shock Wave Therapy

- Hearing Aid Services
- Hip & Shoulder Joint Resurfacing
- Hyperhidrosis Treatment
- Imaging Procedures
- Implantable Cardioverter Defibrillators
- Infertility Advanced Services
- Interspinous Process Decompression Systems (IPD)
- Lenses for Medical Conditions of the Eye
- Lymphedema Pumps, Compression Garments, Appliances
- Mifepristone
- Orthotic Devices
- Penile Implants for Erectile Dysfunction
- Phototherapeutic Keratectomy/Refractive Surgery
- Prolotherapy
- Speech Therapy (Outpatient)

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.

CLAIMS UPDATES

Clinical editing updates and enhancements

MVP is preparing for ICD-10 implementation on October 1, 2014. A requirement for implementation to accommodate processing of ICD-10CM (diagnosis) and ICD-10PCS (procedure) codes is an upgrade to both the claims processing software (FACETS) and the clinical editing software (McKesson® Claims Xten™, "CXT"). MVP has used Claims Xten in conjunction with FACETS since 2009 to facilitate efficient and consistent claim processing and payment. The software applies a predetermined set of rules to each claim so that as many claims as possible can be automatically approved or denied rather than manually reviewed. Clinical edit updates and enhancements will continue to be sourced to nationally recognized correct coding standards including but not limited to:

- American Medical Association (AMA)
- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- National Correct Coding Initiative (NCCI)

The upgrade to FACETS is scheduled for June 2013 and the CXT upgrade will follow during the fourth quarter of 2013. Clinical edits that are currently in place will be carried forward in the upgrade and MVP is working to ensure that the upgrade is seamless for our members and providers. Periodic updates will be provided via the *Healthy Practices* newsletter to keep you informed of any changes that you may see as a result of these transitions.

HIPAA 5010 standards reminder: submitting NPIs

HIPAA 5010 standards for claim submissions are now in effect. Health plans (including MVP Health Care), as well as health care providers, were required to comply with HIPAA 5010 standards for submitting and processing claims electronically as of January 1, 2012.

MVP communicated compliance information to health care providers, including the January 1, 2012 deadline, via our *Healthy Practices* newsletter and by *FastFax*. These communications began in the fall of 2011 and continued through the spring of 2012. **NPIs are a required component of HIPAA 5010 standards for billing.**

If you bill as part of group

You must submit the individual provider's NPI in the rendering provider loop along with the group's NPI in the billing provider loop. The billing provider and rendering provider NPIs should never match each other.

If you bill as a sole practitioner

Only one NPI should be submitted on a claim. Your individual NPI should be input in the billing provider loop. The rendering provider loop should be left blank.

If you bill for a service that was rendered at a location not owned by your practice

The NPI submitted for the servicing location should not match the NPI for the billing provider or the billing provider group. The servicing provider's NPI should be entered on the servicing provider loop and the instructions above should be followed. Facility NPIs are available on the NPPES web site at **www.npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.doupdates**.

Leaving NPIs out of your claims submissions will affect your payments

As of April 1, 2013, MVP's claims processing system will no longer accept claims that do not include NPIs. Claims without NPIs will be returned for your practice to correct and re-submit. Please read the following important information about HIPAA 5010.

If you have any questions about HIPAA 5010 standards

Please refer to the ANSI HIPAA Technical Report Type 3 guide for more information, or contact your software/clearinghouse vendor.

CODING CORNER

Top 10 documentation coding errors

Submitting an inaccurate diagnosis is a compliance risk. It is more important than ever that you follow CMS requirements to ensure compliance. Improper documentation will not be validated and will be considered discrepant.

Listed here are the ten most frequent coding errors documented by the American Academy of Professional Coders (AAPC), March 20, 2013. Please take an extra moment to check your documentation and avoid these errors to help ensure the smoothest possible processing.

1. The record does not contain a legible signature with credential.
2. The Electronic Health Record (EHR) is unauthenticated (not electronically signed).
3. The highest degree of specificity was not assigned the most precise ICD-9-CM code to fully explain the narrative description of the symptom or diagnosis in the medical chart.
4. A discrepancy was found between the diagnosis codes being billed versus the actual written description in the medical record. If the record indicates "depression, NOS" (311 Depressive disorder, not elsewhere classified), but the diagnosis code written on the encounter document is "major depression" (296.20 Major depressive affective disorder, single episode, unspecified), these codes do not match; they map to a different Hierarchical Condition Category (HCC). The diagnosis codes and the description should mirror each other.
5. Documentation does not indicate the diagnoses that are being monitored, evaluated, assessed/addressed or treated (MEAT).
6. Status of cancer is unclear. Treatment is not documented.
7. Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic.
8. Lack of specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia).
9. Chronic conditions or status codes aren't documented in the medical record at least once per year.
10. A link or cause relationship is missing for a diabetic complication, or a mandatory manifestation code is not reported.

PHARMACY UPDATES

Medicare Part D Opioid Overutilization program

Beginning April 1, 2013, Medicare Part D plans are required to monitor members for potential overutilization of opioid containing medications. MVP will reach out to prescribing physicians if members are found to be taking high doses of opioid containing products and/or filling prescriptions from multiple physicians at multiple pharmacies. Impacted prescribers will receive a letter containing the identified patient, their prescription drug history for review and a fax form for responding to MVP. MVP is asking providers who receive these letters to respond promptly using the fax response form. Members will be allowed to continue their current drug regimens only after a coverage determination review is completed at MVP upon the prescriber's request. MVP can also work with prescribing physicians to develop a care management plan if there are concerns about patient overutilization. If a response is not received within fourteen days of the letter, the identified member will be referred to the MVP Health Care Patient Safety Committee for review.

Policy updates effective June 1, 2013

Acthar

- Criteria for coverage for the treatment of multiple sclerosis was updated
- Criteria for coverage for nephrotic syndrome was added
- Exclusions section was updated

Mepron (NEW)

- Effective July 1, 2013
- Establishes prior authorization to ensure appropriate utilization

Pharmacy Programs Administration

- Effective 1/1/2013, benzodiazepines and barbiturates are eligible for Part D coverage
- Medicare home infusion language was updated.

Thalidomide and Thalidomide Derivatives

- Prior therapy criteria was removed
- Combination use with a corticosteroid language was removed

Weight Loss (NEW)

- Effective July 1, 2013
- Prior authorization will be required for all BRAND (only) weight loss products.
- Criteria includes but is not limited to a BMI of 30 or 27 with co-morbidities and/or risk factors

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

- Antibiotic/Antiviral (Oral) Prophylaxis
- Antimalarial Drugs
- Copayment Adjustment for Medical Necessity
- Dificid
- Doryx/Oracea
- Hepatitis B Agents (Pegasys)
- Medicare Part B vs Part D Determinations
- Onychomycosis
- Solodyn
- Xifaxan
- Zyvox

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
Arcapta Neohaler (indacaterol)	COPD
Cometriq (cabozantinib)	Thyroid cancer
Eliquis (apixaban)	Nonvalvular atrial fibrillation
Gattex (teduglutide)	Short bowel syndrome
Giazo (balsalazide)	Ulcerative colitis
Iclusig (ponatinib)	Chronic myeloid leukemia
Juxtapid (lomitapide)	Homozygous familial hypercholesterolemia
Oxtellar XR (oxcarbazepine ER)	Epilepsy
Quillivant XR (methylphenidate ER)	ADHD
Skyla* IUD (levonorgestrel)	Prevention of pregnancy
Vascepa (icosapent ethyl)	Severe hypertriglyceridemia

*Medical drug

Generic drugs added to Formulary (Tier 1)

betamethasone valerate (Luxiq)
buprenorphine/naloxone (Suboxone tabs)
fenofibric acid (Antara)

Drugs added to Formulary (Tier 2)

Delzicol

Drugs covered at Tier 3 (non-formulary for two tier members)

Auvi-Q
Minivelle

Drugs removed from the Formulary (effective June 1, 2013)

Luxiq

**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)*

Perjeta*

*Medical drug

Temodar

Effective June 1, 2013, there will no longer be a quantity limit on Temodar for Option and Option Family members.

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

your healthy practices newsletter is here!