Vermont

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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

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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

Hudson Health Plan to join MVP Health Care® family of companies

MVP Health Care and Hudson Health Plan have signed an agreement under which Hudson, a Tarrytown-based Medicaid managed care organization, will join the MVP family of companies. Both Hudson and MVP are nationally recognized not-for-profit health plans. Financial terms of the agreement are not being disclosed.

"MVP Health Care and Hudson Health Plan together will create a stronger combined company committed to serving Medicaid managed care and Child Health Plus members, and continuing our long-standing relationships in the Hudson Valley," says Denise V. Gonick, President and CEO of MVP Health Care. "This combination brings together two mission-driven, community-oriented companies with similar values. We see many synergies and increased growth opportunities, especially in the upcoming Health Benefit Exchange marketplace. We believe that the sum of our combination will be greater than the individual parts."

Georganne Chapin, President and CEO of Hudson, added, "We are looking forward to joining MVP, an outstanding organization, and believe this combination will create many new opportunities for our customers, employees and communities. We will now become part of an organization with the critical mass necessary to thrive and grow in the rapidly evolving health care field."

No significant changes to Hudson's operations are immediately planned. Hudson will continue to do business as "Hudson Health Plan," and will continue to serve members in Medicaid Managed Care, Child Health Plus and Family Health Plus in Westchester, Dutchess, Orange, Rockland, Ulster and Sullivan counties in New York.

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PROFESSIONAL RELATIONS UPDATES

MVP helps you get ready for Health Benefits Exchanges

The nation's Health Benefit Exchanges open for business on October 1, 2013. These are online marketplaces that will make it simple for individuals and small employer groups to shop for and enroll in health plans for 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. Our overview of the Vermont Health Benefits Exchange is available when you log in to your account at **www.mvphealthcare.com** and go to the *Online Resources* page.

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!

Hudson Health Plan Continued

Like-minded organizations

Gonick and Chapin note that the two companies, which together will serve approximately 733,000 members, share organizational and cultural traits that will provide benefits to all constituencies. Both health plans are forward-thinking, not-for-profit organizations that share a commitment to creating healthier communities. For example, both are among an elite group of six health plans selected to participate in the Comprehensive Primary Care initiative sponsored by the federal Center for Medicare & Medicaid Innovation, in which primary care practices assume responsibility for coordinating care for patients with complex medical needs.

In addition, both plans earn high marks for their services. MVP's commercial and Medicare Advantage programs were among the highest-rated plans in the National Committee for Quality Assurance (NCQA) 2012-2013 Health Insurance Plan Rankings. Hudson has ranked highest in overall satisfaction among Medicaid members in the Hudson Valley since 2003.

Preparing for the Health Insurance Marketplace

Gonick and Chapin believe the combined company will be well positioned to compete as many individuals and small businesses begin to purchase health insurance through the New York State Health Benefit Exchange in October of this year.

"Hudson and MVP both have excellent reputations for customer service, which will be a major consideration for consumers purchasing insurance through the Exchange," Gonick says. Additionally, Hudson has a strong, community-based enrollment program that focuses on individual enrollment. "We believe this enrollment expertise will be invaluable as MVP moves into direct consumer sales in the Exchange environment," Gonick says. Chapin added, "Size and diversity of offerings are important for health plans in the new world of the health insurance marketplaces. A 55-year-old person would like to join a health plan that can continue to cover him when he turns 65. Likewise, if someone is no longer eligible for Medicaid, she might prefer to buy a commercial product from that same insurer. Together, MVP and Hudson now can cover people through all of life's stages and changing needs."

Gonick concludes, "In joining MVP, Hudson becomes part of a larger, more diverse health plan that believes in the value of strengthening and expanding Medicaid managed care. In the combination, MVP benefits from Hudson's proven and noted expertise in and commitment to effectively serving people who qualify for Medicaid, Child Health Plus and other safety net programs in the Hudson Valley."

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, 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

Watch for more details about seminar dates, times and how to register!

Venipuncture codes: modifier change

MVP's current payment policy allows for venipuncture to be reimbursed at physician office labs with codes 36410, 36415 and 36416 with a modifier 90 if the laboratory work is sent to an external lab. Please note that code 36416 is only reimbursable if it is the only service done that day.

Due to a change in CMS modifier requirements, as of June 1, 2013, MVP requires a different modifier for submission of these claims. When submitting a venipuncture claim when laboratory work is sent to an external lab, modifier CG is required. Any claims submitted after that date with a modifier 90 will be denied and must be resubmitted with the appropriate modifier.

If you have questions, please contact the Customer Care Center for Provider Services at **1-800-999-3920**.

Updated ambulatory surgery procedure lists

The *2013 Ambulatory Surgery Procedure and In-Office Procedure* lists were approved by the Quality Improvement Committee (QIC) in June and will be effective October 1, 2013. Coverage for the ambulatory procedures is limited to the ambulatory surgery, outpatient hospital or in-office settings.

Claims submitted with a place of service other than these settings will be denied unless prior authorization is obtained. Use of appropriate place of service setting does not override any existing prior authorization requirements. Coverage for in-office procedures is limited to the in-office place of service. Claims submitted with a place of service other than in-office will be denied unless prior authorization is obtained. The *2013 Ambulatory Surgery Procedure and In-Office Procedure* lists are located on the MVP website at **www.mvphealthcare.com/provider/ny/reference.html.**

MVP offers prenatal and postpartum support

MVP offers the Little Footprints℠ program to new moms to make sure that they—and their newborns—are happy and healthy. MVP's nurses support our members and work with their doctors to make sure they are going for all prenatal visits and taking care of themselves.

Who qualifies?

- MVP Option and MVP Option Family members are automatically eligible for the program.
- Members of MVP Commercial plans are eligible if they are determined to be high-risk.

Participants will receive:

- Books and gifts in the mail about pregnancy and infant care;
- Monthly calls from an MVP nurse to discuss healthy pregnancy habits; and
- Help with New York State's Supplemental Nutrition Program for Women, Infants and Children (WIC), childbirth classes, breastfeeding and support.

Additionally, **MVP Option** and **MVP Option Family** members will receive a $30 gift card by following these steps:

1. Enrolling in the Little Footprints program and staying in touch with their MVP nurse while pregnant.
2. Visiting their OB/GYN after the baby is born.
3. Getting their Little Footprints postcard stamped by the OB/GYN office and sending it back to MVP.

Price Chopper Baby Club

For members living near a Price Chopper grocery store, a free program for new moms is available. As a member of Price Chopper's Baby Club, members receive *Kids News* with articles, parenting tips, baby stories, money saving coupons and more. Upon signing up, they will receive a Baby Club Welcome coupon mailer and ongoing benefits such as:

- Free first and second birthday cake
- Free third and fourth birthday cookies
- Free vitamins for their family

To sign up, members should go to **www.pricechopper.com**, click on *Savings* and then *Baby Club*.

Talk to your pregnant patients about the Little Footprints and Price Chopper Baby Club programs. For more information, call MVP at **1-866-942-7966** or email us at **littlefootprints@mvphealthcare.com**.

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

MVP's Medicare stars ratings

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

One of the clinical quality indicators that CMS has included in the Medicare star rating program is a diabetes treatment measure. This is defined as the number of MVP Medicare Advantage beneficiaries who have filled a prescription for both diabetes and hypertension but did not fill a prescription for an ACEI, ARB or direct renin inhibitor medication using their plan prescription drug benefit. For the past two years, MVP has received much lower results on this measure compared to national results.

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

Beginning July 2013, MVP will send physicians a list of their patients (MVP Medicare members) who, according to the criteria noted above, should be on an ACEI, ARB or direct renin inhibitor in addition to medication for diabetes and a medication for hypertension. Of course, there are some patients who may have a contraindication for these medications. This information is included in MVP's Gaps in Care reports. (See New ACM Reports and Gaps in Care article below.)

We encourage you to prescribe these medications for patients with diabetes and hypertension when appropriate. Additionally, please encourage members to fill their prescriptions using their MVP prescription drug benefit. Most of the ACEI's on the MVP Medicare Part D formulary have no copay. Please refer to the MVP Medicare Part D Formulary.

QUALITY UPDATES

New ACM reports

MVP is pleased to introduce the new Accountable Care Metric (ACM) reports to our suite of clinical reports. These reports contain quality, utilization and pharmacy measures that are specific to the Commercial, Medicare and Medicaid population. Reports are generated for practice sites that have a panel size of at least 250 members during the reporting timeframe for the Commercial and Medicare population. The Medicaid report is produced for groups that see at least 250 members in total during the reporting timeframe.

These reports will be mailed to the office manager of each site. The clinical reporting coordinator for your region will contact you in the near future to discuss the report with you, assist you in identifying potential areas for improvement and answer any questions you might have. If your practice pattern is exemplary, the Clinical Reporting Coordinator will contact you to gain insight into the structures and processes you have in place in your practice that contribute to your performance.

Gaps in Care reports

The second wave of the 2013 prospective Gaps in Care report, which identifies members who have not had preventive screenings, well care visits or immunizations, will be available in July. If a member is lacking services in multiple areas, the information is consolidated on one row to make it easier for you to ensure that all services are provided in a timely fashion. Medicare members with diabetes and hypertension not on an ACEI or ARB are also identified on the report this year. This report is provided in an electronic format (Excel), allowing you to work with the data based on your particular need or interest. All of the reports that you request will be sent to you via MVP's secure email service (ZixMail) to ensure the protection of PHI. If you would like to begin receiving these reports or have questions about any of the reports that you currently receive, please contact Michael Farina, Associate Director Clinical Reporting, **mfarina@mvphealthcare.com.**

Provider Quality Improvement Manual (PQIM) updates

Clinical Guidelines Re-endorsed

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

Low Back Pain Guideline

MVP has adopted the Institute for Clinical Systems Improvement (ICSI) Low Back Pain Guideline which includes changes made in November of 2012. The ICSI guideline is located online at: **www.icsi.org/guidelines_and_more/gl_os_prot/musculoskeletal/low_back_pain/low_back_pain__adult_5**.

There is an Introduction that includes pathophysiology, causation, natural history, cost and impact for primary care along with algorithms for core treatment, red flags and radicular pain. The full guideline is 91 pages long with the first 33 pages, the algorithms and annotations, being the most relevant to MVP's population. The remaining pages offer appendices and supporting evidence for the specific recommendations of the algorithm. There are no conflicts in the guideline with MVP's UM criteria.

Smoking Cessation Guideline

MVP Health Care, as part of its continuing Quality Improvement Program, adopted the Department of Health and Human Services (HHS) Smoking Cessation guideline. The Health and Human Services recommendation includes tips for assessing a patient's readiness to quit and suggested medications available for patients who want to stop

smoking. Additionally, there is a tear sheet containing tips for patients to improve their chances of quitting successfully, as well as an area to document their quit plan. More tools to assist providers with educating their patients on smoking cessation are included in the *Provider Quality Improvement Manual* under *Preventive Health* or visit **www.mvphealthcare.com/provider/qim/preventive_health**.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the May and June 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 epresentative.

Medical policy updates effective August 1, 2013

Bariatric Surgery

Language has been added under Laparoscopic Adjustable Gastric Banding that the banding is considered medically necessary for Commercial members who are not candidates for Roux-en-Y gastric bypass surgery and who meet all the criteria listed in the policy. Language has been clarified concerning Centers of Excellence for both Commercial and Medicare members. Medicare now allows coverage for stand-alone laparoscopic sleeve gastrectomy.

Benign Skin Lesions

There are no criteria changes to the medical policy.

Breast Surgery for Gynecomastia

CPT code 19300 requires prior authorization.

Chiropractic Care

The medical policy was updated with the following:

-When indicated, one passive therapeutic modality may be covered in addition to spinal manipulation if the criteria in the policy are met;

-Ordering of plain films must be related to the spine and medically necessary in order to be covered and are subject to potential retrospective review.

Clinical Guideline Development, Implementation & Review Process

This medical policy outlines the clinical guideline development, implementation and review process.

Continuous Passive Motion Devices

There are no criteria changes to the medical policy.

Deep Brain Stimulation

There are no criteria changes to the medical policy.

Electromyography & Nerve Conduction Studies

Colorectal surgeon was added to the list of specialists allowed to perform needle EMG and nerve conduction studies.

FISH Testing for Bladder Cancer Screening
NEW Policy

Fluorescence In Situ Hybridization (FISH) testing to detect primary bladder cancer in patients with signs/symptoms of bladder cancer or to detect recurrent bladder cancer in patients with a history of bladder cancer, or when used as an adjunct to cystoscopy and urinary cytology has not been found to contribute superior outcomes to cystoscopy/histopathologic evaluation in peer-reviewed literature and is considered to be not medically necessary.

Laminectomy, Hemilaminectomy of the Lumbar Spine

There are no criteria changes to the medical policy.

Medical Policy Development, Implementation & Review Process

The Medical Policy Development policy outlines the procedure for the review of new and existing medical policies. It also speaks to the medical policy Fast Track process.

Negative Pressure Wound Therapy Pumps (NPWT)

The policy follows Medicare criteria. NPWT will be covered only after appropriate standard wound therapy has been tried for at least 30 days and there are no measurable signs of improved healing. Standard wound care has been defined based on specific types of wounds and how healing is measured. Coverage of NPWT will be discontinued when conditions listed in the policy apply.
A statement has been added that subsequent NPWT will be covered when treatment is ordered to continue beyond discharge to the home setting.

PEEK Instrumentation and Devices NEW Policy

Coverage is allowed for FDA approved medically necessary devices that meet criteria in the policy. MVP does not provide additional reimbursement for the use of PEEK requested by the surgeon.

Photodynamic Therapy for Malignant & Non-malignant Indications

Language has been added under PDT for the treatment of non-hyperkeratotic actinic keratosis that coverage is allowed when documentation in the medical record indicates that cryosurgery, topical 5-FU and imiquimod are contraindicated. Initial treatment of the head and neck may be authorized for up to two applications. Requests for additional applications must include documentation of the outcomes of initial treatments and must include photographs of the target lesions.

Septoplasty

There are no criteria changes to the medical policy.

Temporomandibular Joint Dysfunction (TMJ) Vermont

An exclusion has been added for Botulinum Toxin which has not been proven by the FDA for use in TMJ disorders, and medical necessity is not supported in the MVP pharmaceutical compendium for the treatment of TMJ disorders.

Thermal Intradiscal Procedures (TIPS)

TIPS are considered to be not medically necessary and, therefore, not covered. There are no criteria changes to the medical policy.

Vision Therapy (Orthoptics, Eye Exercises)

For Commercial products coverage is allowed for two indications; amblyopia and esotropia. Language has been added to define occlusion therapy and prism adaptation. Medicare does not allow coverage of vision therapy or low vision aids.

List of Medical Policies reviewed and approved in 2012 recommended for approval without changes in May and June 2013:

- Ambulatory Holter Monitor/30-day Cardiac Event Recorder/Monitor
- Artificial Heart
- Cardiac Output Monitor/Thoracic Electrical Bioimpedence
- Cardiac Procedures
- Cardiac Rehabilitation Phase II
- Cold Therapy Devices
- Emergency Department Services
- Foot Care
- Home Uterine Activity Monitoring
- Insulin Infusion Pumps
- Light Therapy for SAD
- Magnetoencephalography
- Mechanized Spinal Distraction Therapy
- Monitored Anesthesia Care
- Needle-free Insulin Injector
- Nesiritide Infusion for Heart Failure – Outpatient
- Pectus Excavatum
- Phototherapy, Photochemotherapy, Excimer Laser Treatment
- Pulmonary Rehabilitation (Respiratory PT)
- Rhinoplasty
- Sacral Nerve Stimulation
- Skin Endpoint Titration
- Spinal Cord Stimulator for Intractable Pain
- Transplants
- Vitiligo
- Wheelchair (Manual)

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

Policy updates effective July 1, 2013

Lyme Disease/IV Antibiotic Treatment

- Policy language was updated to more clearly reflect the prior authorization process by which IV antibiotic treatment is reviewed.

Mepron (NEW)

- Establishes prior authorization to ensure appropriate utilization.

Weight Loss (NEW)

- 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.

Policy updates effective August 1, 2013

Daliresp (ARCHIVE)

- Policy was archived due to appropriate utilization.

Tysabri

- Criteria for JVC antibody testing was added to reflect recent changes to the Prescribing Information.

Policy 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.

Intranasal Steroids

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

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.

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

- Advanced Agents for Pulmonary Hypertension
- Cough and Cold Products (Brands)
- Cystic Fibrosis
- MS Injectables
- Xolair

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
Fulyzaq	Non-infectious diarrhea
Ilevro	Cataract surgery pain
Invokana	Type 2 diabetes
Kadcyla*	Breast cancer
Kazano	Type 2 diabetes
Nesina	Type 2 diabetes
Onmel	Onychomycosis
Oseni	Type 2 diabetes
Pomalyst†	Multiple myeloma
Ravicti*	Urea cycle disorders
Tecfidera*	Multiple sclerosis (relapsing forms)
Uceris	Ulcerative colitis

Generic drugs added to Formulary (Tier 1)

Acyclovir ointment (Zovirax)
Fluvoxamine ext-rel (Luvox CR)
Zoledronic acid (Reclast and Zometa)

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

Binosto
Forfivo XL
Prepopik
Rayos
Sklice
Stribild
Tudorza Pressair
Zaltrap*

*Medical drug

†Must be obtained from CuraScript Specialty Pharmacy

Levoxyl shortage

King Pharmaceuticals has initiated a voluntary recall of Levoxyl due to complaints from pharmacists and patients of an uncharacteristic odor caused by an oxygen-absorbing canister in select bottles of product used to enhance the stability of the product. Due to this recall, there is a current shortage of Levoxyl product on the market. This shortage is anticipated to last in to 2014. MVP has sent letters to members currently taking Levoxyl asking them to contact their prescribing practitioner to discuss an alternative product.

CLAIMS UPDATES

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. We continue to ask for your participation so we can accurately position ourselves to best meet your needs as they relate to provider education and outreach. Our survey results show that almost 43 percent of responders have not yet started working on ICD-10 compliance and 35 percent of responders have not started their system updates for ICD-10. 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. We appreciate your time!

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. 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.

As of June 8, 2013, MVP's claims processing system no longer accepts claims that do not support these billing requirements. MVP extended its original April 1 deadline to allow providers additional time to comply.

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.

MVP upgrades software

MVP continues to upgrade both the claims processing software (FACETS) and the clinical editing software (McKesson Claims Xten™, "CXT") to facilitate ICD-10 implementation on October 1, 2014. The upgrade to FACETS is scheduled for July 2013, and the CXT upgrade will follow in 4Q 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 *Healthy Practices* to keep you informed of any changes that you may see as a result of these transitions.

The McKesson Claims Xten™ Clinical Edits incorporated in the Waste and Abuse Knowledge Pack (January/February 2012 *Healthy Practices*) was implemented in November 2012. Due to a concern related to sourcing that was identified after implementation, the application of the Revenue Code with Procedure (REVCODE_PROC) edit was suspended on February 18, 2013 pending additional research. The sourcing of this edit is McKesson's clinical review. This rule edits HCPCS code(s) submitted with an implant revenue code to determine if the HCPCS code is applicable to the service(s) described by revenue codes 275, 276 or 278. The content contains revenue codes specific to implants; revenue code 275 is specific to "pacemakers", revenue code 276 is specific to "intraocular lenses" and revenue code 278 is for "other implants". This rule addresses outpatient facility claims only. The edit will be reinstated on August 1, 2013.

CLIP & SAVE

DON'T WAIT! START PREPARING NOW FOR ICD-10

PHYSICIAN PRACTICES MUST BE ICD-10 COMPLIANT by the October 1, 2014 deadline set by the Centers for Medicaid & Medicare Services (CMS). To do this you need to begin analyzing your systems and identifying necessary changes now. Below is a checklist of tasks that can help you identify the internal work you need to complete, as well as what you need to do to coordinate with external entities to ensure that your practice is ICD-10 compliant.

- ☐ **IDENTIFY** your current systems and work processes, either electronic or manual, that use ICD-9. The implementation of ICD-10 affects more than your administrative transactions. Identifying which systems currently use ICD-9 will direct you to the processes and systems that need to be updated to ICD-10. To make sure you identify all of the systems and work processes that will be impacted by ICD-10, follow a patient through your office systems from the time they check in until you receive payment from MVP.
- ☐ **TALK** to your current practice management system vendor. When you talk to your vendor, be sure to ask these questions:
  - Can my current system accommodate the data format changes for ICD-10 codes?
  - Will you be upgrading my current system to accommodate the ICD-10 codes?
  - When will the upgrade be available for installation?
  - When will the upgrades to my system be complete?
- ☐ **TALK** to your trading partners (clearinghouses, billing services and payors). Contacting the organizations that you conduct transactions with is the best action you can take to ensure that the transition to ICD-10 is smooth and that your transactions will continue to be processed after the compliance deadline without payment interruptions.
- ☐ **IDENTIFY** potential changes to existing practice work flow and business processes. You may need to consider changes to your existing processes for clinical documentation, encounter forms, quality reporting and public health reporting.
- ☐ **IDENTIFY** staff training needs. Different staff within your practice may require different training based on their involvement with the diagnosis codes. Training should focus on learning the ICD-10 code set and any work flow changes. Your coding staff will need the most training to learn how to use the new code set and correctly capture the diagnosis using ICD-10.
- ☐ **TEST** with your trading partners. Before going "live" with ICD-10 codes you will need to perform test transactions to ensure codes can be sent and received successfully. Since the use of ICD-10 isn't allowed until October 1, 2014, all testing will be done in a testing environment, not a live production environment. MVP plans to conduct external end-to-end testing beginning in January 2014.
- ☐ **BUDGET** for implementation costs. It may be difficult to budget for every cost, but creating some sort of a budget will help you stay on target.

For more information about how MVP is preparing for ICD-10 visit our webpage, **www.mvphealthcare.com/provider/ICD-10_updates_and_faqs**. Remember, all of the planning and testing done now will serve you well when your codes process properly and you get paid in a timely manner.

*Informational source – American Medical Association.

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

your healthy practices newsletter is here!