VMC

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

in this issue

contacting professional relations

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MVP HEALTH CARE

www.mvphealthcare.com

MVP launches new products for January 2013

MVP Health Care is committed to offering health plans to our members and their families that deliver high-quality health care at the lowest possible cost. MVP is introducing two new products that offer practical, affordable ways for our members to get the care they need.

Health care providers will start seeing members with these new products on January 1, 2013. Please remember to check each patient's eligibility and benefit information online. To access an MVP patient's *Benefit Summary* web page:

- Log in at **www.mvphealthcare.com/provider** and click *Patient Inquiry.*
- Enter the patient information and click *Search*.
- Click on the member's name in the search results; this will show the patient's benefit information.
- Click on the patient's health plan name, which will take you to the *Benefit Description: Medical Product* page.
- Click on *Benefit Summary* for a full list of your patient's benefits and out-of-pocket responsibilities.

BridgeWell (Preferred EPO Plans)

BridgeWell from MVP Health Care is an EPO health plan with a twist. It is a Preferred EPO Hybrid plan where members can receive the most commonly-used medical services with no upfront cost (up to a specific dollar limit) before they pay out-of-pocket toward a deductible. Members will have a total of $900 in covered upfront costs for the following services:

- Primary care and urgent care visits (the first $300 for these services, not including annual physicals, which are already covered at no cost to members)
- Lab services (the first $300)
- Radiology services (the first $300 in radiology services including, but not limited to, x-ray, MRI, CT scan or ultrasound)
- Emergency room (ER) visits (the first visit to the ER is covered with a $300 copay rather than being subject to the deductible; additional ER visits after the first visit will be subject to the deductible)

We understand the concerns that providers may have in determining whether your patient has used their $900 in covered upfront costs and/or met the deductible. Simply follow the step-by-step instructions in this article to access your patient's *Benefit Summary* web page. You can view your patient's deductible accumulator, as well as information on your patient's use of his or her BridgeWell ER and primary care benefit.

Family Friendly Plans (Preferred EPO Plans)

MVP is committed to ensuring that our members and their families receive the medical services they need at an affordable cost.

- The Family Friendly Plan has a lower cost share for children ages 0-18 when visiting a primary care physician or the emergency room. This is especially important since kids usually need these visits more often.
- The plan also offers a lower cost share for maternity coverage in the hospital.

To determine your patient's out-of-pocket responsibility, access your patient's *Benefit Summary* web page using the step-by-step instructions in this article.

PROFESSIONAL RELATIONS UPDATES

Working with Express Scripts

Medco, MVP Health Care's pharmacy benefits manager (PBM), recently merged with Express Scripts. It is important to continue to use the information on MVP member ID cards to contact Express Scripts so that MVP members can be recognized as such via our specific contact numbers. MVP is beginning to update ID cards with the Express Scripts name in place of Medco, but the pharmacy information and phone numbers on the ID cards (even if still labeled as Medco) are accurate and should continue to be used. In addition, continue to fax mail order prescriptions to the Medco Pharmacy® (which is now a part of the Express Script family of pharmacies) at the phone number you have always used. MVP will notify you if or when this number changes.

Radiation therapy management

To help ensure appropriate use of new technologies and also to improve patient safety, MVP Health Care expanded the list of outpatient radiation services for which prior authorization is required to include radiation therapy services (Oncology and Radiation Oncology), effective October 29, 2012.

- A list of the CPT® codes that are part of this initiative is posted on the MVP website at **www.mvphealthcare.com**. Login to your account, visit *Online Resources* and click *Radiation Therapy CPT Code List* in the *Resources* section.
- Clinical criteria may be found on the CareCore National website at **www.carecorenational.com**.
- All treatment plans for radiation therapy are required to undergo medical necessity review with CareCore National.
- If you have questions about MVP's radiation therapy management program, please refer to our online Q&A document. To access the Q&A, log in to your account at **www.mvphealthcare.com** and go to *Online Resources*. You also may contact your MVP Professional Relations Representative.

Advanced radiology scheduling service

MVP Health Care began a program with CareCore National on October 29, 2012 to assist members with scheduling advanced radiology services (MRI, MRA, CAT and PET scans).

- MVP requires radiology facilities that perform MRI/MRA, CT/CTA and PET scans to be credentialed with MVP.
- For physician offices to participate in this initiative, MVP will accept proof of accreditation by the Intersocietal Accreditation Committee (IAC) or the American College of Radiology (ACR).
- If you have questions about MVP's radiology scheduling program, please refer to our online Q&A document. To access the Q&A, log in to your account at **www.mvphealthcare.com** and go to *Online Resources*. You also may contact your MVP Professional Relations Representative.

Auditing of professional services claims

As of October 29, 2012, MVP Health Care has contracted with OrthoNet to assist with the ongoing review of professional services claims.

- The initiative entails pending two types of claims for additional review: high-dollar procedure-based surgical claims (approximately 3 percent of surgical claims will be reviewed), and professional services claims from practices that may benefit from additional consultation on coding accuracy.
- If you have questions about this program, please refer to our online Q&A document. To access the Q&A, login to your account at **www.mvphealthcare.com** and go to *Online Resources*. You also may contact your MVP Professional Relations Representative.

MVP to manage health plans for General Electric's Vermont employees

Effective January 1, 2013, MVP Health Care will administer health plans for General Electric (GE) employees and their families in Vermont. The agreement covers two of the three health plans available to GE employees in the state. The GE health plans administered by MVP are designed to control costs and promote health care consumerism, while providing a comprehensive benefit package.

"GE is forward-thinking about many things. At MVP, we share GE's commitment to providing high-quality health care benefits to their employees," said Denise Gonick, MVP's President of Operations. "GE's health plan selection process was careful and rigorous. We are honored to have been selected."

Under the agreement, GE will continue to be self-insured, paying claims for care for employees and their covered family members, but MVP will perform a wide-range of administrative services, including member enrollment, customer service and claims management.

DME prior authorization code list updated

An updated list of durable medical equipment, orthotics and prosthetic codes that require prior authorization is now available on the MVP website at **www.mvphealthcare.com/provider/dme.html**. Also posted is a version of the prior authorization list that includes code descriptions.

Moving closer to ICD-10

MVP is continuing to make progress on the conversion to ICD-10 and will be fully compliant by October 1, 2014. Our plan includes the necessary changes in system design and development, business processes and policy development, as well as communication and training.

Keep up-to-date on our transition to ICD-10 by visiting the MVP website at **www.mvphealthcare.com**, select *Provider* and then *ICD-10 Updates and FAQs*. This page will keep you informed about our progress on the transition to ICD-10, as well as provide the latest ICD-10 information that we think will be helpful to you. If you have a specific ICD-10 question for us, you can use the link available on the right side of the provider portal home page to send the question directly to us. Your question will be forwarded to the individual on our ICD-10 team who can best answer it and you'll get a response as promptly as possible.

Vermont telemedicine mandate

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

If you are the originating site provider (the patient is in your office or facility), you will bill Q3014. If you are the consulting provider, you will bill the appropriate CPT code as if the patient were in your office. To identify the service as a telemedicine service, you must add the GT modifier. For example, if you perform a consult of moderate complexity for a new patient, you would bill a 99214 GT. **For teleophthalmology or teledermatology only**, if the consult is performed using the store and forward means, you will bill the GQ modifier, e.g. 99214 GQ.

If you have any questions, please call your Professional Relations Representative at **1-800-380-3530, option 4**.

New psychiatry CPT codes

A significant revision of the CPT® codes used for billing mental health and substance abuse services will go into effect on January 1, 2013. MVP has a process in place to implement the new CPT codes. We encourage you to purchase a copy of the 2013 edition of the CPT manual from the American Medical Association. Please refer to the American Psychiatric Association **(www.psychiatry.org/practice)** for further information. If you have any questions, please call your Professional Relations representative at **1-800-380-3530, option 4**.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the August and September meetings. Some of the medical policies may reflect new technology, while others clarify existing benefits. All policies may be viewed by logging in to your account at **www.mvphealthcare.com**. Go to *Online Resources* and then *Medical Policies* to view all currently effective and updated policies. If you have questions regarding the medical policies, or wish to obtain a paper copy of a policy, contact your Professional Relations Representative.

Healthy Practices and/or *FastFax* will continue to inform your office about new and updated medical policies. MVP encourages your office to look at all of the revisions and updates on a regular basis in the *Benefit Interpretation Manual* (BIM) located on **www.mvphealthcare.com** in the *Reference* section.

Medical policy updates effective Dec. 1, 2012

Amniotic Membrane Transplant for Treatment of Ocular Conditions (NEW)

Amniotic membrane transplantation may be considered medically necessary for treatment of the conditions listed in the policy when there has been failure of conservative methods of medical management. Prior authorization is required.

Audiologic Screening (OAE) (NEW)

OAE screening is considered medically necessary to determine hearing loss as part of a screening program for infants up to the age of 30 months. OAE diagnostic evaluation is considered medically necessary to confirm the presence or absence of a hearing disorder.

BRCA Testing

The title has been changed from Genetic Testing for BRCA Testing to BRCA Testing. The BRCA1 and BRCA2 criteria have been updated to reflect the 2012 NCCN Guidelines. An additional Indication was added, "diagnosis at any age with > two close blood relatives with pancreatic cancer at any age." Criteria for BRCA Analysis Rearrangement (BART) testing was added to the policy. Prior authorization is required.

Biofeedback Therapy

Coverage is allowed for urinary incontinence, fecal incontinence, constipation, anal spasms, dysfunctional voiding in children, and migraine and tension-type headaches. Biofeedback for treatment of migraine and tension-type headaches is now covered in adults.

Bone Growth Stimulator

There are no changes to the policy. The policy follows Medicare and InterQual® criteria for non-invasive and invasive electric bone growth stimulators.

Breast Pumps (NEW)

This is a new policy which was effective August 1, 2012. The policy addresses coverage of manual and electric breast pumps, and rental of hospital grade electric breast pumps. Prior authorization is required (HCPCS Code E0604). The manual or electric pump is available for infants up to the age of one year.

Burn Garments & Lymphedema Sleeves

There are no changes to the policy. The policy follows Medicare and NYS Medicaid Program criteria for durable medical equipment.

Cosmetic & Reconstructive Services

Language regarding functional impairment has been clarified to state, "documentation must indicate the exact nature of the functional impairment, when applicable, and that the impairment has a significant impact on the patient's activities of daily living (ADLs)."

Heart Transplant Rejection Testing (NEW)

The policy addresses the indications for Allomap® testing.

Intraoperative Neurophysiologic Monitoring

The following changes were made to the policy:

- Language regarding a supervising physician was added to state, "a supervising physician needs to be either physically in attendance in the operating room or present by means of a real-time remote mechanism and provides direct continuous communication to the surgeon during the procedure."
- Monitoring for indications listed in the policy consists of a physician monitoring no more than three cases simultaneously.
- The use of intraoperative monitoring for decompressive procedures without evidence of spinal cord compression, cauda equina syndrome, or without the use of instrumentation is considered to be not medically necessary.

Knee Arthroscopy (NEW)

This new policy follows Medicaid Services Guidelines. Procedures performed for the treatment of degenerative joint disease or osteoarthritis of the knee are not covered. Knee arthroscopy is covered for all products/plans for the following indications: loose bodies, unstable flaps of articular cartilage, disruption of the meniscus, and impinging osteophytes.

Obstructive Sleep Apnea Devices

The policy addresses CPAP, BPAP, APAP and oral appliances. The criteria follow Medicare guidelines. Language was added under oral appliances regarding replacement.

Orthognathic Surgery

There are no changes to the policy.

Prophylactic Mastectomy/Oophorectomy

There are no changes to the policy. The policy follows NCCN and ACOG Guidelines.

Robotic & Computer Assisted Surgery

There are no changes to the policy.

Sinus Surgery – Endoscopic (NEW)

This is a new policy. Indications include criteria for Functional Endoscopic Sinus Surgery (FESS). Image Guided Endoscopic Sinus Surgery is considered part of the FESS procedure and is not eligible for separate payment. Sinus Antrostomy using Dilation Balloon is considered investigational.

Transcatheter Aortic Valve Replacement (TAVR)

Coverage is allowed for all products for members with severe symptomatic aortic valve stenosis who are not candidates for surgical valve replacement when all indications in the policy are met. There is a Medicare Variation as Medicare allows off-label use if done as part of a Clinical Trial.

Ventricular Reduction Surgery

An Indication was added that cardiac myomectomy may be necessary related to cardiac surgery for other conditions. Ventricular reduction surgery, due to the lack of efficacy in peer reviewed literature, is considered to be investigational.

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

- Autologous Chondrocyte Implantation (ACI)
- Breast Reduction Surgery (Reduction Mammoplasty)
- Chemosensitivity & Chemoresistance Assays
- Compression Stockings
- Continuous Glucose Monitoring
- Genetic Counseling & Testing
- Hospice Care
- Laser Treatment for Port Wine Stains
- Oxygen Therapy for Treatment of Cluster Headaches
- Personal Care Services
- Platelet-rich Plasma Injections
- Prosthetic Devices External (Eye & Facial)
- Prosthetic Devices Upper & Lower Limb
- Umbilical Cord Blood Banking
- Wheelchairs (Electric) and Power Scooters
- Yttrium-90 Microspheres for the Treatment of Liver Cancer

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.

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VMC

um policyguide

NOV. 1, 2012

MVP Prior Authorization Process

This *UM Policy Guide* provides a quick reference of prior authorization requirements for MVP's fully-insured and self-insured plans. The guide should be used in coordination with the Prior Authorization Request Form (PARF). All services listed in this document require prior authorization by MVP.

MVP Fully-Insured Plans (HMO, POS, PPO, EPO and Non-Group Indemnity)

If a procedure or service requires prior authorization:

- fax a completed PARF to VMC at **1-802-847-6213** or
- call the VMC Medical Unit at **1-800-639-3881**
- For Non-Group Indemnity, call the MVP Vermont UM Department at **1-800-380-3530**.

MVP Self-Funded Plans (ASO-HMO, ASO-POS, ASO-PPO, ASO-EPO, ASO-Indemnity)

MVP Select Care (ASO) provides self-funded employer groups with customized health benefits packages. All MVP Select Care members have the employer's name and/or logo listed at the top of their ID cards. If your patient is an MVP Select Care (ASO) member:

- fax a completed PARF to MVP at **1-800-280-7346** or
- call the MVP Select Care UM Unit at **1-800-229-5851**.

Prescription Drugs

Self-administered medications covered under the prescription drug rider requiring prior authorization do not appear in this document. They are contained in the Prescription Drug formulary. The formularies are available online at **www.mvphealthcare.com**. See next page for more information about medications administered in the outpatient setting.

Behavioral Health Services

MVP does not accept or require referrals (paper or electronic) from PCPs for behavioral health services when care is rendered by a network practitioner. However, there is a notification requirement and either the practitioner or member must call PrimariLink at **1-800-320-5895** to register care prior to treatment. To request additional visits beyond the initial authorization, behavioral health practitioners must complete and submit an Outpatient Treatment Report (OTR) prior to using all of the initially authorized visits. OTRs are available on the PrimariLink Web site at **www.retreathealthcare.org**.

Please note that PPO plans require notification to PrimariLink. Indemnity plans do not require notification. Effective Sept. 1, 2009, call PrimariLink for Vermont-based MVP Select Care (ASO) members. The three groups are Copley Hospital, Gifford Medical Center, and Northwestern Medical Center. The name of the employer providing the coverage is on the front of the card.

Radiology, scheduling and radiation therapy

MVP has delegated the UM review for all prospective review of Radiation Therapy, MRI/MRA, PET Scan, Nuclear Cardiology, and CT/CTA, and 3D rendering imaging to CareCore National, LLC in Bluffton, SC.

CareCore National (CCN) utilizes evidence-based guidelines and recommendations for imaging from national and international medical societies and evidence-based medicine research centers. For more information on CCN go to **www.mvphealthcare.com/provider**, then *Online Resources* and click on *Provider Resource Manual*. To obtain an authorization please call **1-800-568-0458** and follow the radiology prompts.

Chiropractic services

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

Online Resources

Visit MVP online at **www.mvphealthcare.com** to print a *Prior Authorization Request Form* (PARF), review the *Physician Quality Improvement Manual and Tool Kit*, or access information and forms. Providers also may review the *Benefits Interpretation Manual* (BIM), MVP's medical policies. The BIM allows providers to determine if procedures require an authorization based on CPT code or the member's plan.

Samples of MVP member ID cards

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

In-Office Procedure and Ambulatory Surgery Lists

Participating providers and their office staff can access the *In-Office Procedure and Ambulatory Surgery Lists* at **www.mvphealthcare.com**. Contact your professional relations representative if you prefer a paper copy. Please note:

- The *In-Office Procedure List* details the CPT® codes that MVP requires to be performed in the physician's office. Claims submitted with a place of service other than the physician's office will be denied unless prior authorization is obtained.
- The *Ambulatory Surgery List* specifies the CPT/HCPCS codes that MVP will reimburse when performed in the ambulatory surgery or in-office settings. Claims submitted with an inpatient setting will be denied unless prior authorization is obtained.
- All procedures are subject to the member's plan type and benefits.

PRIOR AUTHORIZATION REQUIREMENTS

All Plan Types

Procedures/Services Requiring Prior Authorization	For Prior Authorization Contact:
• **All Elective Inpatient Admissions** • Inpatient Rehabilitation • Skilled Nursing Facilities • Transplants	• For HMO, POS, EPO and PPO members, fax a completed PARF to VMC at 1-802-847-6213 or call VMC at 1-800-639-3881. • For MVP Select Care (ASO) members, fax a completed PARF to MVP at 1-800-280-7346 or call the Select Care UM Dept. at 1-800-229-5851. • For Non-Group Indemnity members, contact the UM Dept. at 1-800-568-0458.
Medications (IV and most IM dosage forms) given in the office or outpatient setting that require prior authorization are listed here: Commercial Formulary (HMO, POS, PPO, EPO and some ASO plans) and Medicare Part D Formulary (Preferred Gold, GoldAnywhere, GoldValue, USA Care and RxCare). These formularies are located online at **www.mvphealthcare.com**.	For Commercial members, fax a completed form* to 1-800-376-6373. *Forms can be found at **www.mvphealthcare.com/provider**

DME & Home Care Services (HMO, POS, EPO, TriVantage, Non-Group Indemnity, PPO, Preferred Gold HMO-POS, GoldValue HMO-POS, GoldAnywhere PPO, Vermont First and MVP Select Care-ASO Plan Types)

Services	Procedures/Services/Treatments Needed	For Prior Authorization Contact:
Durable Medical Equipment	Durable Medical Equipment (DME) can be dispensed/billed from a physician's or podiatrist's office for stabilization and to prevent further injury, without prior authorization. This is to assure safe mobility and transportation home. The DME item must be billed with the office visit.	• For HMO, POS, EPO and PPO members, contact VMC at 1-800-639-3881. • For MVP Select Care (ASO) or Non-Group Indemnity members, contact the MVP DME Unit at 1-800-452-6966. DME Fax: 1-888-452-5947. Access DME Prior Authorization Code List and other DME information at **https://www.mvphealthcare.com/provider/dme.html** or **http://tinyurl.com/yas3p5o**
Home Care Services *Does not apply to MVP's Non-Group Indemnity Plan*	• Home Infusion • Occupational Therapy** • Speech Therapy** • Nursing** • Physical Therapy** • Terbutaline Therapy	Contact VMC at 1-800-639-3881. For MVP Select Care (ASO) members, contact the UM Dept. at 1-800-777-4793, ext. 2587.
Transplants	For soft tissue and kidney transplants (for VMC HMO, POS, EPO and PPO), contact VMC. For all other transplants and/or for Select Care and Non-Group Indemnity members, contact MVP.	Contact VMC at 1-800-639-3881. Contact MVP at 1-866-942-7966.

Outpatient Imaging Services (HMO, POS, EPO/PPO, HealthFirst, Preferred Gold HMO-POS, GoldValue HMO-POS, GoldAnywhere PPO, MVP CompCare, Option, Vermont First, Alternet and ASO Select Care Plan Types)

Plan Types	Services Requiring Prior Authorization	For Prior Authorization Contact:
Fully-Insured Plans	MRI's, MRA's, CT Scans, PET Scans and Nuclear Cardiology	Care Core National has been delegated to perform imaging reviews for MVP. Call 1-800-568-0458 and follow imaging prompts or submit requests online at **www.carecorenational.com**.
Self-Funded Plans	MRI's, MRA's, CT Scans, PET Scans and Nuclear Cardiology. *Please note that not all self insured plans require prior authorization of imaging.*	For those contracts with imaging authorization requirements call 1-800-568-0458 and follow imaging prompts or submit requests online at **www.carecorenational.com**.

If a physician sends a patient for a clinically urgent imaging study during non-business hours (i.e. evenings, weekends, holidays), the physician should call the MVP Imaging department at 1-800-568-0458 the next business day.

Additional Services (HMO, POS, ASO/HMO, MVP CompCare, Preferred Gold HMO-POS, GoldValue HMO-POS, GoldAnywhere PPO, Vermont First and HMO/ASO/POS Plan Types)

Procedures/Services Requiring Prior Authorization			For Prior Authorization Contact:
• Air Medical Transport/Air Ambulance (For non-emergency transport) • Bariatric Surgery • Blepharoplasty • Botox Injections (Office procedure only) • Brachytherapy of Breast • BRCA 1/BRCA 2 (Genetic testing for breast cancer) • Breast Implantation • Breast Reduction Surgery • Capsule Endoscopy • Cochlear Implants & Osseointegrated Devices • Continuous Glucose Monitoring • Cosmetic vs. Reconstructive Surgery • Deep Brain Stimulation • Dental Services (Accidental Injury to Sound Teeth, Outpatient Services, Prophylactic) • DME/Prosthetics/Orthotics • Endovascular Treatment for AAA and Carotid Artery Disease • ESWT for Plantar Fasciitis (MVP Gold only) • Gaucher's Disease Treatment • Genetic Testing	• Hereditary Angioedema • Hip Resurfacing • Hyperbaric Oxygen Therapy • Hyperhydrosis Treatment • Immunoglobulin Therapy • Implantable Cardiac Defibrillators • IMRT • Infertility (Advanced and/or Secondary), available with Rider - Including drugs (e.g., Follotropins, Menotropins) - GIFT/ZIFT are not covered • Interstim (Sacral Nerve Stimulator) • Left Ventricular Assist Device • Lumbar Laminectomy (Discectomy)* • MSLT – Multiple Sleep Latency Testing • Neuropsychological Testing • Oncotype Testing • Oral Surgery/Orthognathic Surgery • Organ Donor • Panniculectomy/Abdominoplasty • Pectus Excavatum • Penile Implants	• Percutaneous Vertebroplasty/Kyphoplasty • Photodynamic Therapy (Malignant conditions) • Rhinoplasty • Rhizotomy/Radiofrequency Ablation • Sclerotherapy • Septoplasty* • Skin Endpoint Titration • Speech Generating Devices • Spinal Fusion – Lumbosacral* • Spinal Stimulator • Stereotactic Radiosurgery (SRS) • Synagis (Injectable for RSV) • Thoracic Electrical Bioimpedance • TMD/TMJ • Treatment of Obstructive Sleep Apnea (Policies A & B) • UPPP Surgery • Virtual Colonoscopy • VNUS/EVLT • Wound Vacs • Yttrium-90	For HMO and POS members, fax a completed PARF to VMC at 1-802-847-6213 or call VMC at 1-800-639-3881. For MVP Select Care (ASO) members: • Call the Select Care Member Services Dept. at 1-800-229-5851 to confirm member benefits • Fax a completed PARF to MVP at 1-800-280-7346 or call the MVP Select Care UM Dept. at 1-800-229-5851 *Some employer groups offer more than one MVP plan, so be sure to review the member's ID card.*

PPO, EPO Preferred, Catamount Choice and Non-Group Indemnity Plan Types

Procedures/Services Requiring Prior Authorization			For Prior Authorization Contact:
• **Elective Inpatient Admissions** • Advanced Infertility (Available per rider) • Air Transport • Bariatric Surgery • Blepharoplasty • Breast Implantation • Breast Reduction • Cochlear Implants & Osseointegrated Devices • Continuous Glucose Monitoring • Endovascular Treatment for AAA and Carotid Artery Disease	• Genetic Testing† • Hip Resurfacing • Implantable Cardiac Defibrillators • Left Ventricular Assist Device • Lumbar Laminectomy (Discectomy)* • Orthognathic Surgery • Panniculectomy/Abdominoplasty • Pectus Excavatum • Penile Implants • Percutaneous Vertebroplasty/Kyphoplasty	• Rhinoplasty • Rhizotomy/Radiofrequency Ablation • Sacral Nerve Stimulator • Sclerotherapy • Septoplasty* • Spinal Fusion – Lumbosacral* • Spinal Stimulator • TMD/TMJ • UPPP Surgery • Varicose Vein Treatment	• For PPO and EPO members, contact VMC at 1-800-639-3881. • For Non-Group Indemnity members, contact the MVP UM Dept. at 1-800-568-0458. • For MVP Select Care (ASO) members, fax a completed PARF to 1-800-280-7346 or call the MVP Select Care UM Dept. at 1-800-229-5851.

*Denotes when InterQual® criteria is used for the procedure.
**HHA agencies to refer to their contract or the *Provider Resource Manual* (PRM).
Criteria for these procedures may be found in MVP's *Medical Policy (Benefit Interpretation Manual)* at **www.mvphealthcare.com.**
†Applies to EPO Preferred

VMC

Comparison of Plan Types

MVP FULLY-INSURED PLANS

Plan Type	PCP	Referral Required	Prior Auth. Required	Formulary	Reduction of Benefits for Not Notifying MVP of Inpatient Admission	Access to a National Network	Out of Network Benefits
MVP HMO	Yes	No	Yes	Yes	No	No	No
MVP PPO	No	No	Yes	Yes	For Out-of-Network Care Only	Yes	Yes
MVP PPO Select	No	No	Yes	Yes	For Out-of-Network Care Only	No	Yes
Preferred Gold HMO-POS GoldValue HMO-POS	Yes	No	Yes	Yes	No	No	No
MVP Indemnity	No	No	No	No	No	Yes	Yes
MVP EPO	No	No	Yes	Yes	No	No	No
EPO America	No	No	Yes	Yes	No	Yes	No
EPO Preferred	No	No	Yes	Yes	No	Yes	No
Non-Group Indemnity	No	No	Yes	Yes	No	Yes	Yes
MVP CompCare	Yes	Yes	Yes	Yes	No	No	No
Vermont First	No	No	Yes	Yes	No	No	No

MVP SELF-FUNDED (SELECT CARE-ASO) PLANS

Plan Type	PCP	Referral Required	Prior Auth. Required	Formulary	Reduction of Benefits for Not Notifying MVP of Inpatient Admission	Access to a National Network	Out of Network Benefits
ASO-HMO	Yes	No	Yes	Varies by Employer Group	No	No	No
ASO-POS	Yes	No	Yes	Varies by Employer Group	For Out-of-Network Care Only	No	Yes
ASO-PPO	No	No	Varies by Employer Group	Varies by Employer Group	No	No	Yes
ASO-Indemnity	No	No	Varies by Employer Group	Varies by Employer Group	No	No	Yes
ASO-EPO America	No	No	Varies by Employer Group	Varies by Employer Group	No	No	No

Prior authorization requirements can be confirmed with MVP's Utilization Management Department at **1-800-568-0458**. For MVP Select Care (ASO) members, please call **1-800-229-5851**. Full benefits are not listed above.

†Reduction of benefits for the member also applies for same day surgery.

MVP has attempted to capture all prior authorization requirements for each plan type in this document. However, benefit plans, as with member eligibility, are subject to change and do, frequently. If you have questions concerning a member's benefit coverage or about services/procedures not on this document, call our Customer Care Center at **1-888-687-6277** or **1-800-229-5851** for MVP Select Care (ASO) members.

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PHARMACY UPDATES

Enteral therapy Vermont

As published in previous versions of *Healthy Practices*, MVP will be making changes to how our members obtain enteral nutrition products. Effective January 1, 2013, members will be required to obtain enteral formulas from a participating pharmacy. They may obtain enteral formulas from home infusion vendors, but those vendors must be able to bill online through Express Scripts (formerly Medco), MVP's pharmacy benefits manager. A list of all enteral products that will adjudicate through Express Scripts can be found in the *Benefit Interpretation Manual.* If a product is not listed, it will require prior authorization from MVP's pharmacy department effective 1/1/2013. Requests should be submitted on the *Prior Authorization Request Form for Medication* and faxed to the phone number on the bottom of the form. If a request for the enteral formula is denied as not medically necessary, MVP will not cover ancillary supplies and services, including but not limited to pumps, poles, feeding kits, nursing and all home infusion services associated with the administration of the enteral formula. Claims for supplies and services will be subject to retrospective review.

2013 MVP Medicare Part D $0 drugs

Exciting news: MVP Health Care has added more drugs to the $0 tier (Tier 5) for 2013. A few examples of newly added drugs that will be no cost to most MVP Medicare Part D members for 2013 are:

- allopurinol tablets
- citalopram tablets
- ibuoprofen (RX) tablets
- latanoprost eye drops
- naproxen (RX) DR tablets
- paroxetine tablets
- pravastatin tablets
- omeprazole RX capsules
- sertraline tablets
- simvastatin tablets

There are many drugs currently in the $0 tier (Tier 5) that will remain in the $0 tier. Examples include:

- atenolol tablets
- furosemide tablets
- hydrochlorothiazide caps and tabs
- lisinopril tablets
- losartan/HCTZ tablets
- metoprolol tartrate tablets
- ramipril capsules
- metformin/ER tablets
- omeprazole (RX) caps
- alendronate 35 & 70 mg tablets

For a listing of $0 drugs for most MVP Medicare Part D members in 2013, visit: **www.mvphealthcare.com/medicare/documents/Nocostdrugs.pdf**

For the most up-to-date formulary listing, visit **www.mvphealthcare.com**.

1. From the home page, click on *Medicare Members*
2. Click on the county the member lives in
3. Under the *Part D Prescription Drugs* heading, click on *Covered Formulary Drug List and Updates* (or for 2012 information click on *2012 Part D Information*)
4. Click on *2013 MVP Health Care Medicare Part D Covered Drugs (Formulary)*

Policy updates

Antineoplastic Enzyme Inhibitors

- Inlyta, Xalkori, Zelboraf and Zytiga were added to the policy. New indications for Afinitor and Votreint were added. Iressa was removed from the policy as it is no longer available.

Contraceptive Agents and Family Planning

- Implanon was removed; Nexplanon was added.

Direct Renin Inhibitors

- Valturna was removed from the policy.
- Combination use in renal impairment in diabetics was added as an exclusion.

Hepatitis C Treatment

- Pegasys is the preferred agent.

Hepatitis C Protease Inhibitors

- Charts were updated to include specific approval criteria and duration for each agent.
- Drug/drug interactions information was updated.
- Select approval durations were changed.

Hereditary Angioedema

- Firazyre was added. Age, dosing and authorization period limitations were added.

Lyme Disease/IV Antibiotic Treatment

- Clarified documentation requirements for sign and symptoms of early disseminated Lyme disease, clarified testing specific to positive Western Blot for IgM and language was updated regarding duration of therapy for IV antibiotic use.

MDS

- Dacogen and Vidaza were removed from the policy as they no longer require prior authorization.

Multiple Sclerosis, Select Oral Agents

- EDSS chart was removed.
- New contraindications added to the Gilenya exclusion section.
- Language regarding DMT stable dosing for Ampyra was updated.
- Alternative language was added with respect to percent improvement criteria.
- Alternative to EDSS score language was added.
- Policy will be re-reviewed as additional medications become available.

Oforta-Policy ARCHIVED

Osteoporosis Medications

- New indication for Prolia was incorporated in the policy criteria.

Pharmacy Programs Administration

- Language was added for members in a Vermont product. If an adverse determination is appealed, MVP must cover the drug during the appeals process.

Thalidomide and Thalidomide Derivatives

- Kyprolis was added to the policy per NCCN guidelines.

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

- Acthar
- Actimmune
- Alpha-1 Antitrypsin Inhibitors
- Formulary Exception for Non-Covered Drugs
- Growth Hormone
- Ixempra
- Jevtana
- Kuvan
- Lovaza
- Mozobil
- Pradaxa
- RSV/Synagis
- Smasca
- Thrombopoiesis-Stimulating Proteins
- Xgeva
- Xyrem
- Zorbtive

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
Combivent Respimat	COPD
Dymista	Seasonal allergic rhinitis
Perjeta*	HER2-positive metastatic breast cancer
Pertzye	Exocrine pancreatic insufficiency
Zetonna	Seasonal & perennial allergic rhinitis

*Medical drug

Generic drugs added to Formulary (Tier 1)

abacavir tablets (Ziagen)
calcipotriene (Dovonex Cream)
desloratadine (Clarinex)
montelukast (Singulair)
Next Choice One Step (Plan B One Step)
olanzapine/fluoxetine (Symbyax)
pioglitazone (Actos)
pioglitazone/met (ActoPlus Met)
quinine sulfate (Qualaquin)
tolterodine (Detrol)

Drugs removed from the Formulary*

Actos	Diovan/Diovan HCT
ActoPlus Met	Singulair
Detrol	Ziagen tablets
Dovonex Cream	

*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)

Bydureon	Onfi
Eylea*	Oxecta
Erwinaze*	Picato
Ferriprox	Rectiv
Jentadueto	Viread

*Medical drug

UM UPDATE

Updated in-office list effective February 1, 2013

Updates to the in-office procedure list were approved by the Quality Improvement Committee (QIC) in September and will be effective February 1, 2013. 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 updated *In-Office Procedure* list for 2013 is located on the MVP website at **www.mvphealthcare.com/provider/ny/reference.html.**

GOVERNMENT PROGRAMS UPDATES

NEW online wellness portal for MVP Medicare Advantage members

MVP has partnered with Healthways to provide Well-Being Connect™, a Medicare-specific wellness portal designed to inspire improved overall health and help members achieve specific goals. Whether members are interested in being more active, eating healthier, losing weight, quitting tobacco use or relieving stress, Well-Being Connect has the tools and resources to help.

Well-Being Connect features the Healthways Well-Being Assessment™, which members must complete in order to access the full portal. The Assessment is designed to evaluate members' overall health, lifestyle and well-being. Upon completion, they will be given a full health report and personalized well-being action plan. Based on results from the Well-Being Assessment, outbound telephonic lifestyle coaching will be offered to members interested in modifying behavioral health risk factors (i.e. tobacco use, nutrition, physical activity, stress).

Impact on providers

Members are encouraged to share their health report with their physician. Reimbursement for wellness visits covered by Medicare requires that providers work with members to complete a health risk assessment and a personal prevention plan; MVP's new capabilities will assist with the completion of these required documents.

Well-Being Connect is a component of MVP's suite of wellness services called the Well-Being Program.

More information is available at **www.mvphealthcare.com**; under *Medicare Members*, click on *Live Well* and then *Well-Being Program*

MVP Health Care's participation with the Catamount Program

MVP Health Care has proudly supported and participated in Vermont's Catamount Insurance Program since it started in October 2007. The Catamount program, however, has been repealed by the State of Vermont and will end entirely as of January 1, 2014.

In anticipation of this change, MVP will end its participation in the Catamount Health insurance program on December 31, 2012. Since there will be no more MVP members under this product, any contract or fee schedule references to Catamount will become void after this date.

MVP has informed subscribers that they while they will no longer be able to receive Catamount through MVP, they may be eligible to remain in the Catamount program through Blue Cross and Blue Shield of VT and continue to have the same coverage. They will receive information in the mail regarding their options.

If members have questions about the transition, we recommend they contact the Vermont Health Care Ombudsman's office at **800-917-7787.**

This decision by MVP to exit the Catamount program will allow us to focus on continuing to work with Vermont officials in preparing for the creation of the new health benefits exchange, which we are actively engaged in helping the State of Vermont get up and running by October of 2013.

MVP is committed to Vermont and will continue to sell and service our other commercial insurance products in the Green Mountain State. We value your participation with MVP and look forward to working with you so that our members — your patients — can continue to receive the quality care you provide them with in a way that is beneficial to us all.

Healthy Practices will now be delivered to your email

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

If you have any questions or choose to opt out at any time, please email **ecommunications@mvphealthcare.com.**

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your healthy practices newsletter is here!