HEALTHY PRACTICES™

MVP HEALTH CARE

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A BI-MONTHLY PUBLICATION FOR MVP-PARTICIPATING HEALTH CARE PROVIDERS

New York/Vermont

IN THIS ISSUE

MVP Provider Directory

You can search the current MVP Provider Network at **www.mvphealthcare.com**. Select *Find a Doctor* to search for current primary care providers and specialists online.

UN-CASHED CHECKS?

Visit **longlostmoney.com** to see if MVP has any un-cashed checks in your name or in the name of your business.

Contacting MVP Professional Relations

MVP Corporate Headquarters	**1-888-363-9485**
Southern Tier	**1-800-688-0379**
Central New York	**1-800-888-9635**
Midstate	**1-800-568-3668**
Mid-Hudson	**1-800-666-1762**
Buffalo and Rochester	**1-800-684-9286**
Vermont	**1-800-380-3530**

Denise V. Gonick
President & CEO

We welcome your comments.

Healthy Practices
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Professional Relations Dept.
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Schenectady, NY 12301

www.mvphealthcare.com

PROFESSIONAL RELATIONS UPDATE

Launch of the MVP Health Care Electronic Claim Adjustment Request Form

MVP is excited to announce the implementation of an additional, web-based self-service claim adjustment capability for providers and their office staff.

The new portal capability offers more timely adjustment processing by allowing providers/staff to:

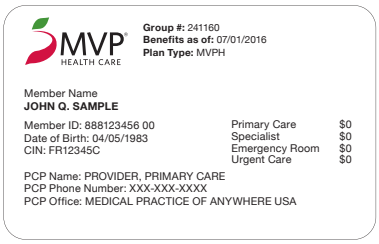
- electronically submit claim adjustment requests that formerly were submitted on paper for corrected CMS 1500 and UB-04 claim forms
- electronically attach supporting documentation such as office notes, invoices, or EOBs
- check the status of any claim adjustment requests that have been submitted through the MVP provider portal
- view letters in response to submitted/processed claim adjustment requests via the MVP provider portal

For an informational presentation on accessing the electronic claim adjustment request form, visit **www.mvphealthcare.com** and select *Providers*, then *Summary of CARF Enhancement*.

New Member ID Cards for MVP Harmonious Health Care Plan

As previously communicated, effective July 1, 2016, MVP Health Care began offering the MVP Harmonious Health Care Plan, a Medicaid Managed Care Health and Recovery Plan (HARP). This plan is available to existing Medicaid members age 21 and over who are identified by New York State with serious mental illness and/or substance use disorders.

All eligible MVP Harmonious Health Care Plan members received new ID cards with Plan Type **MVPH**. Please note that reimbursement for covered medical services will be at your MVP Medicaid Managed Care contracted rate.


MVP HEALTH CARE
Group #: 241160
Benefits as of: 07/01/2016
Plan Type: MVPH
Member Name
JOHN Q. SAMPLE
Member ID: 888123456 00
Date of Birth: 04/05/1983
CIN: FR12345C
Primary Care $0
Specialist $0
Emergency Room $0
Urgent Care $0
PCP Name: PROVIDER, PRIMARY CARE
PCP Phone Number: XXX-XXX-XXXX
PCP Office: MEDICAL PRACTICE OF ANYWHERE USA

Sample MVP Harmonious Health Care Plan Member ID Card

For more information about HARP, visit **www.mvphealthcare.com** and select *Providers*, then *Reference*, and then *MVP Harmonious Health Care Plan FAQs*.

If you have any additional questions, please contact your Professional Relations Representative or Provider Services at **1-800-247-6550**.

Online Provider Demographic Information Review Request

The Centers for Medicare and Medicaid Services (CMS) regulation 42 CFR 422.111(b)(3) and (h)(2)(ii), 422.112, 423.128(d)(2) requires that all health plans work with their provider network on a quarterly basis to confirm the

provider demographic information in the online directory is accurate. Providers are required to review their demographic information in the MVP directory and notify MVP of any inaccuracies in the directory to be updated.

MVP is asking all participating providers to follow these steps:

Step 1: Visit **www.mvphealthcare.com** and select *Find a Doctor,* then *Search by Provider.*

Step 2: Search for the provider(s) in your practice and review the following demographic information for accuracy:

- Ability to accept new patients
- Street address or missing addresses
- Phone number
- Other changes that affect availability to patients. (e.g. handicap accessible, specialty changes)

Step 3: If demographic information is identified as incorrect, please submit the correct information to MVP using the *MVP Providers Change of Information* form. To download this form, visit **www.mvphealthcare.com** and select *Providers*, then *Forms*. Delegated providers should contact their delegate administrator to update demographic information.

Step 4: If the update applies to multiple providers in the group, please include a roster of all providers to whom the change applies, including the providers name and NPI, when you submit updates to MVP.

Step 5: Fax or email the completed *Providers Change of Information* form to the appropriate regional fax or email address listed on the form.

Step 6: *Login* at **www.caqh.com** and make any demographic updates to your Council for Affordable Quality Healthcare (CAQH) profile so it matches the information you are submitting to MVP and re-attest your CAQH.

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 at **www.mvphealthcare.com**. To access the BIM, *Log In* to your account, select *Online Resources,* and then *BIM* under *Policies*. The *Current Updates* page of the *BIM* lists all medical policy 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, 2016

Skin Endpoint Titration: CPT codes 95017 and 95081 do not require prior authorization effective June 1, 2016.

Neuropsychological Testing: CPT codes 96118 and 96119 do not require prior authorization effective June 1, 2016.

Medical Policy Updates Effective August 1, 2016

Amniotic Membrane Transplant: There are no criteria changes to the medical policy.

Breast Pumps: Breast pump supplies are now covered for MVP Medicaid products. Previously, breast pump supplies were not covered for MVP Medicaid products.

Cryoablation of Breast Fibroadenomas: ARCHIVED
The Cryoablation of Breast Fibroadenomas medical policy is archived.

Dental Care Services Accidental Injury: There are no criteria changes to the medical policy.

Experimental and Investigational Procedures: The medical policy was updated to include language for coverage Phase 4 clinical trials.

External Breast Prosthesis: There are no criteria changes to the medical policy.

Gas Permeable Scleral Contact Lenses: NEW POLICY
This is a new medical policy. The policy addresses coverage criteria for BostonSight® PROSE, which is an ocular surface ecosystem prosthesis. It is intended for use in individuals with ocular surface disease and corneal issues. The BostonSight® PROSE device can only be ordered by an ophthalmologist.

Heart Transplant Rejection Testing: There are no criteria changes to the medical policy.

High Frequency Chest Wall Oscillation Devices: There are no criteria changes to the medical policy.

Hip Surgery for Femoroacetabular Impingement, Acetabular Labral Tears, and Snapping Hip Syndrome: There are no criteria changes to the medical policy.

Home Prothrombin Time Monitoring: ARCHIVED
The Home Prothrombin Time Monitoring medical policy is archived.

Immunizations Childhood/Adolescent/Adult: There are no criteria changes to the medical policy.

Magnetoencephalography: There are no criteria changes to the medical policy.

Mechanical Stretching Devices: There are no criteria changes to the medical policy.

Monitored Anesthesia Care: There are no criteria changes to the medical policy.

Needle-free Insulin Injectors: There are no criteria changes to the medical policy.

Obstructive Sleep Apnea: Diagnosis: CPT codes 95810 and 95811 do not require prior authorization effective August 1, 2016. There are no criteria changes to the medical policy.

Panniculectomy/Abdominoplasty: There are no criteria changes to the medical policy.

Phototherapy, Photochemotherapy, and Excimer Laser Therapy: There are no criteria changes to the medical policy.

Prosthetic Devices Upper and Lower Limb: The medical policy was updated with the following Medicare National Coverage Determination (NCD) Prosthetic Devices language changes:

- Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of foot or foot addition (such as L5968 Multiaxial ankle with dorsiflex).
- Foot covers are included in the codes for a prosthetic foot component and are not separately covered upon initial issue of a new prosthetic.
- Socket replacements are considered medically necessary if there is adequate documentation of functional and/or physiological need. It is recognized that there are situations where the explanation includes, but is not limited to, changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive patient weight or prosthetic demands of very active amputees.
- Codes L5940–L5960 for ultra-light materials may only be used when materials such as carbon fiber, fiberglass, Kevlar®, or other advanced composite lamination materials are used in the fabrication of a socket for an endoskeletal prosthesis. They are not used for ultralight materials used in other components of a prosthesis, e.g., knee/shin system, pylon, ankle, foot, etc. For codes L5940–L5960, the unit of service is per limb.
- Vacuum pump systems (codes L5781, L5782) are covered when:
  - the patient has a documented clinical condition of volume variation with objective measurements of the residual limb provided over a period of time (excluding any volume change due to weight gain, weight loss, the normal atrophy process, growth, or systemic issues such as vascular or cardiac issues which would cause volume changes despite the use of vacuum technology);
  - documented clinical condition of moisture retention with evidence of dermatological issues caused by the excessive perspiration;
  - a history of slow or non-healing wounds;
  - or reduced proprioceptive capabilities.
- Protective outer surface covering systems (codes L5962, L5964, and L5966) are specialized covers intended to be worn over an existing prosthesis. They are used by a beneficiary who has special needs for protection against unusually harsh environmental situations where it is necessary to protect the lower limb prosthesis beyond the level of that which is afforded by codes L5704–L5707. They are not covered for cosmetic or convenience reasons, or for everyday usage in a typical environment. Documentation to support medical necessity of a protective outer surface covering system (L5962, L5964, and L5966) must indicate the type of extraordinary activities that would justify the need for extra protection afforded by this highly durable item.
- Partial Foot Code L5000—(partial foot, shoe insert with longitudinal arch toe filler) is covered when member has partial foot or toe amputations.

Skin Endpoint Titration: CPT codes 95017 and 95081 do not require prior authorization effective 6/1/16. There are no criteria changes to the medical policy.

Transplants: There are no criteria changes to the medical policy.

Scoliosis Bracing: There are no criteria changes to the medical policy.

Vitiligo Treatment: MVP continues with its longstanding position that vitiligo is cosmetic and treatments for vitiligo are not medically necessary.

Medical Policies for Approval Without Changes in May and June 2016:

Bariatric surgery
Benign Skin Lesions
Electromyography & Nerve Conduction Studies
Evaluation of New Technology
FISH Testing for Bladder Cancer Screening
Imaging Procedures
Implantable Cardioverter Defibrillators
Medical Policy Development, Impl, Review Process

Negative Pressure Wound Therapy Pumps
Photodynamic Therapy for Malignant and Non-Malignant Indications
Temporomandibular Joint Dysfunction (TMJ) NY/NH
Temporomandibular Joint Dysfunction (TMJ) VT
Transcatheter Aortic Valve Replacement
Vision Therapy (Orthoptics, Eye Exercises)

PROVIDER RESOURCE MANUAL UPDATES

Modifier 50

MVP recently identified a system configuration error that allowed reimbursement for procedures billed with a Modifier 50 and a quantity of two. Retro adjustments are being performed on overpayments as they are identified per MVP Modifier Payment Policy.

Description

Used to report bilateral procedures (CPT codes 10040–69990) performed in the same operative session and radiology procedures performed bilaterally. Bilateral procedures that are performed at the same session should be identified by adding Modifier 50 to the appropriate five digit code.

Rule

- Identify that a second (bilateral) procedure has been performed by adding Modifier 50 to the procedure code.
- Do not report two line items to indicate a bilateral procedure.
- Do not use modifier with surgical procedures identified by their terminology as "bilateral" (e.g., 27395, lengthening of hamstring tendon, multiple, bilateral), or as "unilateral or bilateral" (e.g., 52290, cystourethroscopy, with meatotomy, unilateral or bilateral).
- Report only one unit of service when Modifier 50 is reported.
- Modifier 50 should not be appended to a claim when appending the LT/RT modifiers.

Reimbursement

150 percent of the providers contracted rate.

Effective September 1, 2016, MVP will implement an upfront system edit to automatically deny any claim billed with Modifier 50 and quantity of two as a billing error. Modifier 50 denotes a bilateral procedure which represents this procedure has occurred twice. Billing this modifier with a quantity of two is considered incorrect billing.

For more information on MVP's payment policies, found in the *MVP Provider Resource Manual*, visit **www.mvphealthcare.com** and select *Providers*, then *Log In* to your provider portal account, then select *Provider Snapshot* in the gray box, then *Online Resources,* and then *Online Resources*. All Payment Policies are found in Section 15.

PHARMACY UPDATES

Metformin ER

Fortamet, Glumetza, and their generic equivalents require prior authorization for Commercial, Exchange, and Medicaid members.

Glucophage

Glucophage XR and their generic equivalents are covered without prior authorization and must be used prior to Fortamet and Glumetza. Please see the Metformin ER policy for full criteria.

Policy Updates Effective June 1, 2016

Hepatitis C Treatment

- Updated drugs to include Daklinza and Zepatier. Harvoni is preferred for all plans and Zepatier is co-preferred for Medicaid.
- Eliminated Hepatitis C disease severity criteria, such as fibrosis or certain co-morbidities
- Updated treatment criteria and durations of approval to reflect current AASLD/IDSA guidelines

Policy Updates Effective July 1, 2016

Diclofenac (topical) Products

- Add generic Voltaren gel (diclofenac 1% gel) to policy
- Changed criteria for Voltaren gel to failure of two oral NSAIDs

Metformin ER

- Fortamet and the generic equivalent will require prior authorization
- Criteria for Glumetza and the generic equivalent was updated

Policy Updates Effective August 1, 2016

Inhaled Corticosteroids and Combination

- Prior authorization removed for Advair

Xolair

- Chronic idiopathic urticaria criteria updated

Cystic Fibrosis (Select Agents for Inhalation)

- Medicare variation updated to included non-cystic fibrosis bronchiectasis for Tobi

Cystic Fibrosis (Select Oral agents)

- CFQ-R removed for extension criteria and replaced with decrease in number of pulmonary exacerbations for baseline

Idiopathic Pulmonary Fibrosis

- No changes

Cough and Cold Products (Brands)

- No changes

Preventive Services-Medications

- Iron supplementation for children age 6–12 months will no longer be covered as of October 1, 2016

Formulary Updates for Commercial, Medicaid, and Marketplace Formularies

New Drugs (recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid)

Drug Name	Indication
Vraylar	Bipolar I and schizophrenia
Vistogard	Fluoruracil or capecitabine overdose
Odefsey	HIV
Idelvion	Hemophilia B
Otiprio	Used with tympanostomy tube placement
Spritam	Partial onset and Myoclonic seizures
Allzital	Tension headache
Alprolix	Hemophilia B
Taltz	Plaque psoriasis
Defitelio	VOD
Cinqair	Severe asthma
Venclexta	CLL
Impavido	Leishmaniasis
Evomela	Multiple Myeloma
Wilate	Hemophillia A
Adzenys XR	ADHD
Zembrace	Migraine
Descovy	HIV

Drugs Added to Formulary (Tier 1 for Commercial/ Medicaid and Tier 2 for Marketplace)

Darifenacin ER
Doxepin cream
Frovatriptan
Mometasone nasal
Zolpidem SL

Drugs Removed from Prior Authorization

Zarxio
Synjardy
Envarsus XR
Tolak
Odomzo
Lonsurf
Aristada
Varubi

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