HEALTHY PRACTICES™

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New York

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 professionals and specialists online.

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	**1-800-999-3920**

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President & CEO

We welcome your comments.

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Professional Relations Dept.
PO Box 2207
Schenectady, NY 12301

www.mvphealthcare.com

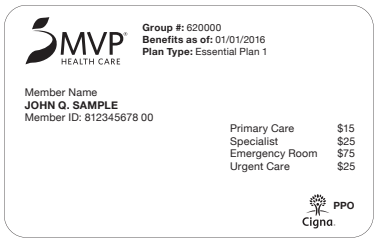
PROFESSIONAL RELATIONS UPDATES

MVP Announces the New Essential Health Plan Product

MVP is introducing the Essential Health Plan Product beginning January 1, 2016. The Essential Health Plan is a new product for New York residents that costs less than most health plans, but offers the same essential health benefits. The new product is available to lower income individuals who do not qualify for Medicaid or Child Health Plus, and it offers a low premium.

The product provides free preventive care services and has no deductible for all non-preventive medical services such as specialist doctor visits, inpatient and outpatient hospital care, tests, and prescriptions.

MVP has a limited network for the Essential Health Plan product. Providers who are participating with these products received a letter and amendment to their MVP contract. If you would like to determine if you or another physician are participating for this product with MVP Health Care, please use the Provider search tool at **www.mvphealthcare.com** and select *Find a Doctor*.



*Sample MVP Member ID card for the **Essential Health Plan** product.*

New CMS Place of Service Code

Effective January 1, 2016, The Center for Medicare & Medicaid Services (CMS) has issued a new **place of service code (POS)** for services provided in the outpatient setting that is not located on the hospital campus:

POS 19—"A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization."

POS 19 does not replace place of service 22 which is used for outpatient services provided on the hospitals campus.

POS 22—"A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick for injured persons who do not require hospitalization or institutionalization."

Reimbursement for services at POS 19 will remain the same as when billed with POS 22. In addition, all medical and payment policies that apply to POS 22 will apply to the new POS 19 for January 1, 2016 dates of service and after. This includes MVP's in-office procedure list. These services will continue to require prior authorization if being billed with POS 19. Providers should specify the POS 19 or POS 22 when submitting prior authorization requests.

Hearing Aid Discount Program

MVP is collaborating with TruHearing™, a national hearing aid benefits company that provides high-quality hearing aids and excellent member service, to offer a hearing aid discount program on certain health plans. Effective January 1, 2016, this new program will offer significant savings and lower members' out-of-pocket costs on hearing aids.

This cost savings program will be extended to Medicare Advantage plan members, individual and small group plan members with a hearing aid benefit for children per the Federal Affordable Care Act (ACA), and MVP members whose employer purchases additional hearing aid coverage. MVP will encourage eligible members to take advantage of hearing aid savings through TruHearing. Please confirm the hearing aid coverage available under your patient's health plan.

HEDIS Spotlight

While traditional HEDIS measures rely on claims report and medical record review, NCQA is introducing a new domain of measures for health plans to report in 2016, Electronic Clinical Data System (ECDS). This set of measures will incorporate additional data from providers' electronic systems and will help to reduce the limitations typically associated with HEDIS reporting. ECDS utilizes data that is automated and accessible by the health care team at the point of care. This may include Electronic Health Records (EHRs), disease registries, or Case/Disease Management systems that allow any provider who interacts with the member to access them.

NCQA is rolling out this new HEDIS domain with the focus on depression measures and the use of a validated tool for assessment and monitoring. The depression measures are described in more detail below.

DMS—Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS): Compliance is achieved when members (12 and older) with a diagnosis of depression or dysthymia have a PHQ-9 or PHQ-A tool administered at least once in a four-month period.

Two rates are reported:

1. **Inclusion in ECDS**-the percentage of members (12 and older) with a diagnosis of depression or dysthymia who are included in an ECDS.
2. **Utilization of PHQ**-the percentage of members (12 and older) with a diagnosis of depression or dysthymia who have a PHQ-9 or PHQ-A score in their record. Members are those who are included in the ECDS and have an outpatient encounter during the measurement year.

DRR—Depression Remission or Response for Adolescents and Adults: This measure focuses on improvement in depression symptoms. Compliance is achieved when members (12 and older) with a diagnosis of depression and elevated PHQ-9 or PHQ-A score have evidence of response or remission within five to seven months of the elevated score.

Four rates are reported:

1. **Inclusion in ECDS**-the percentage of members (12 and older) with a diagnosis of depression or dysthymia who are included in an ECDS.
2. **Depression Remission**-the percentage of members who achieved remission (PHQ score <5) within five to seven months after the initial elevated PHQ score.
3. **Depression Response**-the percentage of members who were not in remission and showed response within five to seven months after the initial elevated PHQ score.
4. **Total**-the sum of the Remission and Response performance rates.

DSF—Depression Screening and Follow-Up for Adolescents and Adults: Compliance is achieved when members (12 and up) who screened positive for depression receive appropriate follow-up care.

Three rates are reported:

1. **Inclusion in ECDS**–the percentage of members (12 and older) with a diagnosis of depression or dysthymia who are included in an ECDS.
2. **Depression Screening**-the percentage of members who were screened for clinical depression using a standardized tool.
3. **Follow-Up on Positive Screen**-the percentage of members who screened positive for depression and received appropriate follow-up care within 30 days. Follow-up care is defined as one of the following:
   - Receiving a prescription for an anti-depressant medication
   - A follow-up Behavioral Health (BH) encounter/visit (including assessment, therapy, medication management, acute care)
   - A follow-up outpatient visit (with a non-BH provider) with a diagnosis of depression (NOTE: this visit may NOT occur on the same day as the positive depression screen. For a visit on the same day to count there must be documentation of additional screening indicating no depression).

- A follow-up with a case manager with documented assessment of depression symptoms (any encounter that addresses depression symptoms that does **not** occur on same day as positive depression screen).

MVP offers free tools to providers to assist them in screening and management of depression that can be found in the *Behavioral Health* section of the *Provider Quality Improvement Manual*. Visit **www.mvphealthcare.com** and select *Providers*, then *Provider Quality Improvement Manual*, and then *Behavioral Health*.

For more information on these new HEDIS measures please visit NCQA at **http://ncqa.org/ECDS**.

Provider Demographic Changes

MVP makes every effort to ensure a provider's demographic information is accurate in our systems.

If you or your practice have changes in demographic and/or participation status, it is important to promptly notify MVP.

Examples of status changes are:

- No longer accepting patients
- Address, telephone number, or tax ID number changes

To report demographic changes to MVP, please complete a Provider Demographic Change form. The forms can be downloaded by visiting **www.mvphealthcare.com** and selecting *Providers*, then *Forms*, and then the appropriate form under *Provider Demographic Change Forms*. Please return the completed demographic change form on letterhead to the appropriate fax number or email below.

East New York and Massachusetts
518-836-3278
eastpr@mvphealthcare.com

Central, Mid-State, or Southern Tier New York
315-736-7002
centralprdept@mvphealthcare.com

Rochester
1-800-684-9286
RocProviderChanges@mvphealthcare.com

Mid-Hudson New York
914-372-2035
MidHudsonprdept@mvphealthcare.com

For more information, see section 4 of the *Provider Resource Manual*.

PROVIDER QUALITY IMPROVEMENT MANUAL UPDATE

Clinical Guidelines Re-Endorsed

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

Heart Failure in Adults Guideline

MVP continues to endorse the Institute for Clinical Systems Improvement Heart Failure in Adults guideline found at **www.icsi.org/guidelines_and_more/gl_os_prot/cardiovascular/heart_failure_2/heart_failure_in_adults__guideline_.html**.

Page 1 of the guideline contains an algorithm which is supported by the remaining pages of annotations and evidence. Paper copies of these recommendations are available by calling the MVP Quality Improvement Department at **1-800-777-4793** extension 12247. The recommendations will also be available in an update to the MVP Provider Quality Improvement Manual. The current edition of the manual is located at **www.mvphealthcare.com**. Select *Providers* and then *Provider Quality Improvement Manual* under the *Quality Programs* heading.

Guidelines for the Management and Treatment of HIV/AIDS

MVP continues to endorse the guideline, Primary Care Approach to the HIV-Infected Patient. This guideline can be found at **www.hivguidelines.org/clinical-guidelines/adults/primary-care-approach-to-the-hiv-infected-patient**. Additional AIDS guidelines relating to adults, children, adolescents, and the prevention of HIV transmission during the perinatal period can be found at **www.hivguidelines.org/Content.aspx**.

HIV testing information is also available at **www.health.ny.gov/diseases/aids/providers/testing**.

MVP Health Care updates its clinical guidelines at least every two years. The review process is also initiated when new scientific evidence or national standards are published.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the November and December 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 select *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 December 1, 2015

Imaging Procedures: Digital breast tomosynthesis has been removed from the MVP Imaging Procedures medical policy as a non-covered procedure.

As of December 1, 2015, MVP Health Care has changed its position on coverage of breast tomosynthesis (CPT code 77061 Digital breast tomosynthesis; unilateral, CPT code 77062 Digital breast tomosynthesis; bilateral and CPT 77063 Screening digital breast tomosynthesis, bilateral [List separately in addition to code for primary procedure]). Services provided on and after December 1,2015 will be covered.

This change was made after considering the medical literature, opinions of participating providers, and the impact on women's health.

Breast tomosynthesis that is with a screening mammogram (CPT 77063 Screening digital breast tomosynthesis, bilateral [List separately in addition to code for primary procedure]) will follow the same co-payment, co-insurance, and deductible guidelines as other Affordable Care Act services.

Medical Policy Updates Effective January 1, 2016

Custodial Care NEW: This policy addresses custodial care coverage provided within a nursing home for MVP Medicaid members. When skilled nursing facility guidelines are not met, custodial care may be covered as outlined in the policy. All inpatient custodial nursing home care requires prior authorization. When custodial care within the nursing home is provided in conjunction with daily skilled nursing care or restorative therapy that meets guidelines for skilled nursing facility coverage, the custodial care is covered as part of the member's skilled nursing facility benefit. When skilled nursing facility coverage guidelines are not met, custodial care may be covered according to the criteria outlined in this policy.

Medical Policy Updates Effective February 1, 2016

Alopecia/Wigs/Scalp Prosthesis: There are no changes to the medical policy criteria.

Autism Spectrum Disorders NY: There are no changes to the medical policy criteria.

Blepharoplasty/Browlift/Ptosis Repair: There are no changes to the medical policy criteria.

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

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

Clinical Guidelines Development, Implementation, and Review: There are no changes to the medical policy process.

Cochlear Implants and Osseointegrated Devices: The bone conduction threshold measurements for unilateral and bilateral osseointegrated devices were updated to reflect the measurements to the specific device.

Dental Care Services: Medical Services for Complications of Dental Services: There are no changes to the medical policy criteria.

Electrical Stimulation Devices and Therapies: The medical policy is updated to state that electrical tumor treatment field therapy is considered investigational and therefore not covered. Cefaly device for treatment/prevention of migraine headaches is considered investigational and therefore not covered.

Erectile Dysfunction: The Medicaid variation was updated to state section vacuum systems only covered for diagnosis of impotence. The Medicare variation now states vacuum systems not covered.

Extracorporeal Shockwave Therapy: The Medicare variation now states extracorporeal shock wave therapy is not covered.

Ground Ambulance/Ambulette Services: The Medicare Variation was updated to state "when criteria for paramedic intercept services are not met the claim will be denied administratively."

Hearing Aid Services: Medicare variation added to state that coverage is available through TruHearing™ as of January 1, 2016.

Investigational Procedures, Devices, Medical Treatments, and Tests: This policy outlines all mentioned procedures considered Experimental and Investigational and not covered. The following devices and tests have been added to the policy:

- Bioimpedance Devices for Detection of Lymphedema (e.g. ImpediMed LDex™)
- Hydrogel Spacing for Radiotherapy of Prostate Cancer (e.g. SpaceOAR)
- Invasive Congestive Heart Failure Monitoring (e.g. CardioMEMS)
- Multi-biomarker for Rheumatoid Arthritis (Vectra DA®) there is a Medicare Variation. Vectra DA is covered for Medicare members only when policy criteria is met.
- Rupture of Membranes (ROM) testing in Pregnancy(AmniSure ROM Test [PAMG-1] , ROM Plus® Fetal Membrane Rupture test [PP12, AFP], and Actim® PROM [GFBP-1] test for Detection of Fetal Membrane Rupture
- Serum Antibodies for the Diagnosis and Monitoring of Inflammatory Bowel Disease (e.g. Anser IFX and Anser ADA)
- Shoulder joint resurfacing

Lenses for Medical Conditions of the Eye: There are no changes to the medical policy criteria.

Orthotic Devices: The policy was updated to state elastic support garments do not meet the definition of a brace and are not covered.

Psychological Testing: Computerized psychological testing is now covered when psychological testing policy criteria are met.

Therapeutic Footwear for Diabetics: There are no changes to the medical policy criteria.

Wheelchairs (Manual): There are no changes to the medical policy criteria.

Medical Policies for approval without changes in November 2015:

- Speech Generating Devices
- Botulinum Toxin Treatment
- Obstructive Sleep Apnea: Surgical

CARING FOR THE ELDERLY

Talk to Patients About Bladder Control and Prostate Problems

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

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

Preventing Falls By the Elderly

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

There are several key actions you can take to help your elderly patients reduce the risk of falling:

- Develop a plan with your patient.
- Ask your patient, directly, if they have fallen or felt unsteady on their feet.
- Encourage regular exercise—discuss an exercise program with your patient that focuses on increasing leg strength and balance.
- Review their medications for those that may cause drowsiness or dizziness as a side-effect or in combination with other medications.
- Ensure they have their vision checked and their eyewear is adjusted appropriately.
- Discuss tripping/slipping hazards in the home and ways to eliminate them.

MVP offers several tools to assist practitioners in fall prevention. The MVP Physician Quality Improvement Manual includes helpful sheets from the CDC guide, *Preventing Falls: How to Develop Community-Based Fall Prevention Programs for Older Adults*. This guide includes information on how to build an effective program as well as useful tools:

- Fall Risk Assessment
- Sample Medication Review Form

- Sample Home Fall Prevention Safety Checklist

MVP has developed some tools to assist physicians and their office staff that can be utilized for the above assessments. Visit **www.mvphealthcare.com** and select *Providers*, then *Provider Quality Improvement Manual (PQIM)* in the *Quality Programs* section, and then *Caring for Older Adults*. In addition to assessment tools, you also will find a brochure for your patients about fall prevention and a link to the Beer's List of high-risk medications.

PHARMACY UPDATES

Prior Authorization for Nexium and Esomperazole

Nexium now requires prior authorization for Commercial and Exchange members.

Esomperazole may be obtained without prior authorization but does have a quantity limit of two capsules per day.

Pharmacy Policy Updates Effective January 1, 2016

Select Hypnotics: Hetlioz and Belsomra added to policy

Xyrem: Criteria updated to include 18 years and old; doses greater than 9 grams per night added as exclusion

Multiple Sclerosis Agents: Added Plegridy and Lemtrada

Gralise: Removed related policy (Qutenza)

Benlysta: Updated indications

Government Programs Over-the Counter (OTC) Drug Coverage: No changes

Patient Medication Safety: Changed PBM from Express Scripts to Cvs/caremark

Cystic Fibrosis (selected agents for inhalation): Removed Kalydeco from policy

Cystic Fibrosis (select oral agents): New policy-requiring prior authorization for Kalydeco and Orkambi

Lidocaine (topical) Products-New policy for Medicaid members: Lidocaine cream, ointment, gel, lotion, jelly, and patches will require prior authorization

Glumetza NEW: Glumezta will require prior authorization

Immunoglobulin Therapy: HyQvia added to policy

Prostate Cancer: Removed criteria that patient must no longer be responding to docetaxel

Pharmacy Policy Updates Effective February 1, 2016

Lyme Disease/IV Antibiotic Treatment: No changes

Onychomycosis: Jublia and Kerydin added to policy

Antibiotic/Antiviral (oral) Prophylaxis: No changes

Zyvox: Linezolid tablets added to policy

Antimalarial Drugs: Policy archived

Solodyn: No changes

Overactive Bladder (oral) Treatment: Policy archived

Intranasal Corticosteroids: Flonase and fluticasone nasal spray will no longer be covered due to availability of OTC version

Valchlor: Added NCCN criteria to policy

Quantity Limits for Prescription Drugs

- Antimalarial Drugs added to policy
- Quantity limits removed for smoking cessation products for Medicaid members

2016 Formulary Changes

2016 Formulary Exclusions for Commercial Members

The following medications will require medical exception approval.

Excluded NSAIDs	Formulary Alternatives
Arthrotec	Generic NSAIDs
Duexis	Celebrex
Naprelan	Flector
Pennsaid	Voltaren Gel
Vimovo	Zipsor

Excluded Gastrointestinal Agent	Formulary Alternatives
Relistor	Movantik

Excluded Narcotic Antagonist	Formulary Alternatives
Zubsolv	Generic agents Bunavail Suboxone

Excluded Respiratory Agents	Formulary Alternatives
Proair HFA	Ventolin
Tudorza Pressair	Spiriva
Proventil HFA	Spiriva Respimat
Incruse Ellipta	
Xopenex HFA	

2016 Formulary Changes for Medicaid Members

The following medications will be non-formulary and require prior authorization.

Non-Formulary Diabetic Agents	Formulary Alternatives
Byetta	Victoza
Kombiglyze	Januvia
Onglyza	Tanzeum
	Tradjenta

2016 Formulary Changes for Medicare Part D Members

The following is not a complete list of changes. Please refer to the 2016 Medicare Formulary document by visiting **www.mvphealthcare.com** and selecting *Provicers*, then *2016 Covered Formulary Drug List & Updates*, and then *2016 MVP Health Care Comprehensive Medicare Part D Covered Drugs (Formulary) (published 10/2015)* under the *Pharmacy* heading.

The following medications will be non-formulary and require an exception request.

Non-Formulary Respiratory Products	Formulary Alternatives
Dulera	Advair
Foradil	Serevent
ProAir	Anoro Ellipta
Tudorza	Incruse
Spiriva	Arnuity Ellipta
Arcapta	Flovent
Asmanex	Ventolin
Qvar	Breo Ellipta
	Ellipta

The following medications will now require prior authorization for Medicare Part D members for 2016.

- Amitriptyline*, Doxepin*, and Imipramine*
- Digoxin 0.25mg*
- Aubagio

**Considered high risk by CMS, consider formulary alternatives.*

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
Zarxio	Neutropenia
Addyi	Hypoactive sexual desire disorder
Synjardy	Type 2 diabetes
Envarsus XR	Prophylaxis of organ rejection
Tolak	Multiple actinic or solar keratosis
Odomzo	Basal cell carcinoma
Lonsurf	Colorectal cancer
Aristada	Schizophrenia
Varubi	Chemotherapy induced N/V
Durlaza	Risk reduction in prior stroke or cardiac patients

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

Rivastigmine path
Fluvastatin XL
Paliperidone ER
Pimozide
Dutasteride

Drugs Removed from Prior Authorization

Lyparza	Rytary
Evotaz	Duopa
Movantik	Ibrance
Incruse Elipta	Savaysa Opdivo
Lenvima	Farydak Toujeo
Evekeo	Glyxambi
Sotylize	Signifor LAR
Mircera	Cresemba
Liletta	Jadenu

MVP HEALTH CARE

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