HEALTHY PRACTICES™

MVP HEALTH CARE

VOLUME 12
NUMBER 6
NOVEMBER/DECEMBER 2016

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
MVP Health Care, Inc.
Professional Relations Dept.
PO Box 2207
Schenectady, NY 12301

www.mvphealthcare.com

PROFESSIONAL RELATIONS UPDATES

New for 2017: Telemedicine Benefit

MVP Health Care will cover "direct-to-consumer" telemedicine—we're calling it **24/7 online doctor visits**—beginning January 1, 2017, subject to regulatory restrictions and approval. We will cover two main types of visits, urgent care and behavioral health, as well as ancillary services such as nutrition and lactation consultations. We are including the telemedicine benefit in all of our fully insured, Medicare, Medicaid, and Essential plans upon renewal starting January 1, 2017. Our ASO groups will have the option of adding the telemedicine benefit to their coverage, also. The only exceptions will be members in Vermont Small Group and Individual plans, who will receive this benefit in 2018 upon renewal, subject to regulatory restrictions and approval.

We see this as an opportunity to evolve patient care for our members. With the telemedicine benefit, our members will be able to see a health care provider for urgent care anytime, day or night, via a mobile device or a computer with a webcam. (Other types of online consultations will be available with extended hours, but not overnight.) It could be an MD, it could be a behavioral health practitioner, a dietician, or a lactation consultant...this is about giving our members a convenient new way to access health care.

Telemedicine is not meant to replace the very valuable PCP relationship, or other in-person provider visits. From a cost perspective, while online visits will be less expensive than urgent care or low-acuity ER visits, the cost-share for members who use this benefit will not be lower than a PCP visit. Again, this is about giving our members more options and greater access to care.

We think it's a great benefit for busy families, for those with limited mobility, and for patients who may be incapacitated for any number of reasons. Telemedicine will enable them all to access health care from the comfort of their home.

(Continued on page 2)

A New Look for the MVP Website

The MVP website homepage and content for our customers and partners—members, employers, brokers, and health care providers—have a bold new look. We also have streamlined and organized the resources we have online for you so that it's easy to find the answers and support you need. Visit **mvphealthcare.com** and select *Providers* at the top of the redesigned homepage for access to content and alerts, or *log in* to your account. The features available to you post login have remained unchanged.

(***Telemedicine Benefit*** *continued from page 1)*

The telemedicine benefit will be especially valuable for behavioral health care. Talking to a behavioral health practitioner from home can make a huge difference for our members, not just in their comfort level, but also by removing a possible reason to skip treatment.

Following are answers to what we anticipate are your most pressing questions about the new telemedicine benefit.

Q: Who are MVP's partners in bringing this telemedicine benefit to MVP members?

A: MVP is working with American Well, a leading telehealth technology platform, and the Online Care Group (OCG), the American Well affiliated virtual provider group.

Q: Who will have access to this?

A: MVP will be including this benefit in our fully-insured plans upon renewal, beginning January 1, 2017. (Note: members of fully-insured Vermont Small Group and Individual plans will receive this benefit upon renewal beginning January 1, 2018.)

MVP will also be including this benefit in Medicare, Medicaid, and Essential Plans, upon renewal, beginning January 1, 2017. (Note: SmartFund℠ MSA and RxCare PDP members will not receive this benefit.)

Self-funded (ASO) groups may choose to add this benefit beginning January 1, 2017.

Q: What can it be used for?

A: MVP members can access non-emergency care online, keeping in mind that it's not intended to replace their Primary Care Physician (PCP). The most common urgent care and behavioral health diagnoses include: sinusitis, upper respiratory infections/flu, pharyngitis, skin disorders, urinary tract infection, bronchitis, conjunctivitis, earache, back pain, stress, mood disorders, insomnia, and eating disorders.

Q: How is this different from the 24/7 Nurse Advice Line service offered by MVP?

A: A call to the 24/7 Nurse Advice Line will connect a member to a nurse for information and advice. The registered nurses often help a member decide on a course of action (go to the ER, urgent care center, their regular doctor, or treat at home).

A telemedicine visit is an online visit with an actual doctor or other health care provider who can give a diagnosis, treatment, and in some cases, a prescription.

Q: What is the Online Care Group network of health care professionals?

A: We are inviting MVP-participating health care providers to join an already well-established and reputable national network (the Online Care Group, or OCG) to provide these services. Here are some other facts about the network:

- National, telehealth-only physician network
- Employed physicians, not a call center
- Board-certified, multi-state licensure
- Credentialed to NCQA/URAC standards
- 24/7/365 availability
- Average wait time is less that six minutes

Behavioral Health Facts

- Over 400 network providers
- Services can be accessed via web-based computer, tablet, or mobile device
- Access standard goals are seven days from request for therapy/counseling services (appointments available seven days per week, 7 am–11 pm in each time zone)
- Therapy/counseling services are currently available within one day of request
- Self-scheduling feature

Q: What types of health care professionals will an MVP member be able to connect with online?

A: For urgent care: emergency medical primary and family physicians, and pediatricians

For behavioral health: licensed social workers and PHD-level psychologists

For nutrition and wellness: registered dieticians and lactation consultants

Q: What standards are in place to ensure MVP members will see highly-qualified health care professionals?

A: Clinical services will be provided by OCG, the nation's first and largest primary care group devoted to telehealth. In addition to being able to see health care providers who are already part of the MVP network (those who choose to also participate with OCG).

All health care professionals in OCG:

- Have an average 15 years of experience in primary and urgent care
- Are U.S. board-certified, licensed, and credentialed
- Have profiles, so you can see their education and practice experience

(Continued on page 3)

(***Telemedicine Benefit*** *continued from page 2)*

- Are rated by other patients, so you can review and select the doctor that meets your needs

Q: How can an MVP-participating provider join OCG and offer online visits to MVP members?

A: MVP providers may contact American Well directly to begin the process of joining OCG.

- Visit **americanwell.com** and select *Group Practices*, and then *Join Online Care Group* for information
- Providers may email a CV to **ocg.recruiting@americanwell.com**

OCG handles credentialing and training:

- Providers complete an online application and background check
- Once submitted, the approval takes 4–6 weeks
- While waiting for approval, providers complete self-paced eLearning
- Once approved, providers complete a "certification" session, which is a mock patient visit

Q: Can an MVP provider choose to see only his/her patients, is it limited to MVP members, or will they be scheduling online doctor visits with anyone, anywhere?

A: We are inviting MVP-participating providers to take part in the telemedicine program (by joining OCG). If you choose to participate and you are seeing patients at the time they start an online visit, they can connect with you by using the search feature they will see when they log in online.

At this time, MVP providers who join OCG do not have the option to choose to see only their patients. Provider participation in OCG is strictly voluntary with the understanding that patients may or may not be MVP members.

In the future, local provider groups may be able to set up their own private practices on this platform. We will provide more information and requirements for groups interested in this as details emerge.

Q: Is there any risk to a provider's quality and performance rates if his/her MVP patients use the telemedicine benefit instead of going into a provider's office?

A: Telemedicine visits will generally impact a physician's quality scores in the same way that their patient's use of brick-and-mortar urgent care centers might (they may be excluded from some measures), meaning that telemedicine can have both positive and negative effects. MVP has reviewed the possible impact on various measures and it appears that, overall, the effect should be neutral or slightly positive.

Q: How can Primary Care Physicians (PCP) receive copies of summaries from a telemedicine visit?

A: There are different ways that PCPs can receive copies of the visit summary:

- First, members will always have the ability to access, print, and download visit summaries to share with their PCPs.
- Second, a member may input their PCP's email address at the time of the visit to have a summary sent via email afterward.
- Finally, a member may authorize MVP to send the visit summary to their PCP. This requires the member to have up-to-date PCP information in their MVP online account, and for MVP to have their PCP's email address on file.

Medicaid Expansion

MVP Health Care began offering Medicaid Managed Care and Child Health Plus in six new counties on October 1, 2016. The counties are Columbia, Greene, Lewis, Oneida, Putnam, and Washington. MVP will also offer the Essential Plan in all of these counties except Putnam.

It is all part of MVP's commitment to offering low or no-cost coverage across New York State. MVP is also committed to educating all members about the available plan benefits. These include regular checkups, dental and vision care, emergency treatment, and much more.

Residents of these counties can apply for coverage through MVP on the NY State of Health™ Marketplace at **nystateofhealth.ny.gov**. They can also call the MVP Customer Care Center at **1-800-852-7826**, Monday–Friday, 8:30 am–5 pm, to speak with an MVP Representative who can help with the application.

MVP Member ID Cards

MVP continuously seeks to improve our business processes. We are excited to announce that beginning in January 2017, MVP will launch a newly designed Member ID card for our Commercial, Medicaid, and Medicare members. The 2017 ID card templates feature more clearly organized member and provider information and a new design element in an effort to make health care simpler for our members, providers, and employer groups.

Changes on Commercial ID Cards

- Simplified member information
- Prominently called-out plan name

- Brand element
- Rx Group, Rx Bin, and PCN on front of the card

Changes on Medicare ID Cards

The Medicare cards will have a newly designed front with a larger font size for the information members may need to reference, such as their ID number, co-pays, and contact information on the back of the card, making everything easier to read.

Changes on the Medicaid ID Cards

The Medicaid cards will also have a newly designed front and contact information on the back of the card that is separated by *For Members* and *For Providers* sub-headings to clearly identify the appropriate contact information for users.

For further information concerning all new designed ID card samples, please visit our 2017 Provider Manual Resource on or after January 1, 2017.

New Participating Provider Enrollment Toolkit

MVP is committed to offering the highest-quality health care to our members. We do that by aligning with the best health care practitioners. In an effort to improve MVPs credentialing and registration process for providers, we are in the process of creating a step-by-step guide to walk you through the most appropriate process to becoming an MVP participating provider. The new toolkit will be available in print for providers in the coming weeks and will be posted on-line in the next couple months. This will help providers determine which process they should follow, provide them with a checklist of required information, and all the required forms they will need to move through the process quickly and efficiently.

Watch for more information regarding this exciting new development that will help simplify the credentialing and registration process with MVP.

MVP Annual Notices

As part of our commitment to the accreditation standards of the National Committee for Quality Assurance (NCQA), and to comply with state and federal government regulations, MVP publishes an annual summary of important information for practitioners and providers. This notice includes the following topics:

- MVP's recognition of members' rights and responsibilities
- Complaints and appeals processes
- Confidentiality and privacy policies, including measures taken by MVP to protect oral, written and electronic PHI
- Medical management decisions
- Pharmacy benefit management
- Transition of patient care
- Emergency services
- Assessment of technology
- Medical record standards and guidelines
- Information about MVP's Quality Improvement Program
- Reporting suspected insurance fraud and abuse
- MVP's stance on physician self-treatment and treatment of immediate family members
- MVP's efforts to meet members' special, cultural, and linguistic needs

To access MVP's annual notices for health care providers, visit **mvphealthcare.com** and select *Privacy & Compliance* at the bottom of the homepage. If you would like to receive a printed copy of this information, please call Professional Relations at the phone number shown on the front page of this newsletter.

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, or address, phone number, or tax ID number changes.

To report demographic changes to MVP, please complete a Provider Demographic Change form. To download the form, visit **www.mvphealthcare.com** and select *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
585-327-5747
RocProviderChanges@mvphealthcare.com

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

Vermont
802-264-6555
vpr@mvphealthcare.com

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

QUALITY IMPROVEMENT UPDATES

Marketplace (Exchange) Primary Care Improvement Program Coming January 2017

In an effort to improve the quality of care our Marketplace (Exchange) members receive, MVP is offering a new provider incentive program for the following HEDIS measures:

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Adolescent Well-Care Visits
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years
- Well-Child Visits in the First 15 Months of Life
- Immunizations for Adolescents
- Comprehensive Diabetes Care
- Medication Management for People with Asthma
- Annual Monitoring for Patients on Persistent Medications

More details on this incentive program will be distributed in December 2016.

HEDIS/QARR and CAHPS Measure Spotlight

HEDIS (Healthcare Effectiveness Data & Information Set) is a nationally recognized set of healthcare quality measures that contribute significantly to MVP's NCQA (National Committee for Quality Assurance) accreditation score. MVP collects HEDIS data from claims information and by chart review in many offices across our service area. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks members to evaluate their experiences with health care via a survey tool. MVP monitors its performance in these measures on an ongoing basis and submits results to NCQA annually.

The state and federal government also monitor these measure results to assess the quality of care that the members of health plans receive from their contracted physicians. The CMS Star Rating Program and state QARR (Quality Assurance Reporting Requirements) programs are two examples.

Information on Select HEDIS and CAHPS Measures

(CBP) Controlling High Blood Pressure

Compliance is achieved when individuals with a diagnosis of hypertension (HTN) meet the following criteria:

- Members 18–59 years of age whose blood pressure is <140/90 mmHg.
- Members 60–85 years of age with a diagnosis of diabetes whose blood pressure is <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose blood pressure is <150/90 mm Hg.

Chart documentation of compliant blood pressure readings accepted by HEDIS includes:

- Both a systolic and diastolic reading within the above parameters.
- Blood pressure reading must be exact, no rounding up or down.
- Documentation of a Hypertension diagnosis* with the blood pressure readings following the date of diagnosis.

**Documentation of a hypertension diagnosis must be found in the chart on or before June 30 of the measurement year.*

(SMD) Diabetes Monitoring for People with Diabetes and Schizophrenia

This measure focuses on members with a diagnosis of diabetes and schizophrenia between the ages of 18 and 64. Compliance is achieved when the member has BOTH a Hemoglobin A1c (HbA1c) test AND an LDL-C test performed during the measurement year.

Note: evidence of the HbA1c and LDL-C tests must be obtained from claim/encounter or automated laboratory data, NOT chart review.

(SAA) Adherence to Antipsychotic Medications for Individuals With Schizophrenia

This measure focuses on medication adherence for anti-psychotics for members ages 19–64 with schizophrenia. Compliance is met if individuals were dispensed an anti-psychotic and remained on it for at least 80 percent of their treatment period. The treatment period starts on the date the initial prescription was filled and concludes on the last day of the measurement year.

Note: evidence for this measure must be obtained from claim/encounter data, NOT chart review.

(CAHPS) CAHPS Composite Measure: Shared Decision Making

The shared decision making questions are asked of members who indicated on the survey that their doctor discussed starting or stopping a prescription medication within the last 12 months. Compliance is met if the member answers "yes" to the following:

- Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
- Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?
- When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

Major Changes for HEDIS 2017!

Two measures have had significant changes/clarifications from the last HEDIS reporting year that we wanted to make you aware of:

Immunizations for Adolescents (IMA): The HPV vaccine has been added as a requirement for this measure. Previously this measure focused on adolescents receiving one dose of meningococcal conjugate vaccine and one dose of Tdap by their thirteenth birthday. Now this measure also requires three doses of HPV vaccine by age 13 (for both boys and girls).

Breast Cancer Screening (BCS): NCQA clarified that this measure does not count diagnostic screenings as a "pass". The intent of this measure is to evaluate primary screenings. Diagnostic screenings, biopsies, ultrasounds, and MRIs do not count toward this measure as they are not considered appropriate methods for primary breast cancer screening.

Colorectal Cancer Screening (COL): Following the recent release of updated guidelines from the USPSTF for colorectal cancer screening, NCQA has added additional tests that may count for this measure:

- CT colonography during the measurement year or the four years prior to the measurement year.

  Please note: MVP does not cover CT colonography when used for screening. This is consistent with CMS guidance.
- FIT-DNA test during the measurement year or the two years prior to the measurement year.

We understand the challenges providers face to help educate patients and influence behavior change; especially when dealing with mental illness/substance abuse. We have various resources and tips available to support your work—some of these are described below:

Controlling High Blood Pressure Measure

- Educate patients on the importance of exercise, low-sodium diet, and quitting smoking to control blood pressure.
- If appropriate, prescribe medication to lower blood pressure. Refer to MVP's guidelines which are based on the 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC8). A copy of the JNC 8 can be found at **jamanetwork.com/journals/jama/fullarticle/1791497**.
- For those on anti-hypertensives, remind them about the importance of taking medication as prescribed and reporting any side-effects. Schedule regular follow-up visits to ensure medications are working appropriately and make adjustments as needed.
- During the office visit be sure to take the blood pressure reading more than once. If it was high at the beginning of the visit re-take it at the end of the visit and be sure to document both readings.

Schizophrenia Measures

People with schizophrenia or bipolar disorder who also have diabetes have a higher mortality rate than those with diabetes alone. These individuals need close monitoring by both their behavioral health specialist and primary care provider to ensure they are taking their medications as prescribed and obtaining the appropriate diabetes testing. Key points to remember when working with these patients:

- Educate patients on the importance of medication adherence. Reach out to their prescribing behavioral health provider if patient complains of issues such as side effects interfering with their ability to take the medication.
- Educate patients with diabetes on their increased risk of heart disease and about the importance of regular HbA1c testing and LDL-C testing. Follow through with patient to determine if they had their testing done (if blood not drawn in office).
- Do not rely on the patient to following through with scheduling appointments. Ensure they have a follow-up scheduled before leaving the office.

If an appointment is missed have office staff call to assess why and re-schedule.

- Keep an open line of communication with their behavioral health provider. Ensure they have a complete overview of the member's health issues and concerns and work together to coordinate any medications the member is prescribed. Communication and coordination among providers is essential to help reduce medical errors and improve quality, safety, and continuity of care.
- Work with MVP's Case Management Department and/or MVP's behavioral health partner, Beacon Health Options, for members with diabetes and schizophrenia to identify appropriate members for outreach. Case Managers can work with the member over the phone to provide education to assist in the management of their diabetes, ensure they are getting the appropriate testing for diabetes, are adhering to prescribed medications, and following up with their appointments. To refer a member, please call **1-866-942-7966** for more information.
- Beacon Health Options also has "PCP Toolkit" that provides general information about Beacon support for PCPs in addressing behavioral health issues. To access the toolkit, visit **beaconhealthstrategies.com** and select *Providers*, and then *PCP Toolkit*.

CAHPS Measures

- Communicate with patients thoroughly and in a manner they understand.
- When starting a new medication, be sure to talk to your patients about the benefits and risks of taking the medication.
- If discontinuing a medication, let the patient know the reasons why.
- Let the patient share in the decision-making regarding treatment. Ask them for their opinion about what is best for them.
- Allow time for them to ask questions and verify that they understand.
- Review your Accountable Care Metric (ACM) report that MVP produces annually. The ACM report includes CAHPS measures. Three composites are reported: Getting Care Quickly, Care Coordination, and Communicate Well. This report depicts the practices rate for each measure, compared to the health plan rate. Results are taken into consideration in MVP's Pay for Performance (P4P) program. They are delivered via secure e-mail. Throughout the year Clinical Reporting Coordinators visit practices to review their results and provide them with suggestions and tools to help improve their performance. For any questions on these reports or to schedule a visit, please contact Mike Farina at **518-388-2463** at **mfarina@mvphealthcare.com**.

[1]Vinogradova, Y., C. Coupland, J. Hippisley-Cox, S. Whyte, C. Penny. 2010. "Effects of Severe Mental Illness on Survival of People with Diabetes." British Journal of Psychiatry 197:272–7. Accessed September 26, 2016 at: **http://bjp.rcpsych.org/content/197/4/272.long**.

CARING FOR OLDER ADULTS

Medicare Wellness Visits and New Incentive Program

MVP would like to remind providers that MVP Medicare Advantage plan members are entitled to and are encouraged to have a Welcome to Medicare or Annual Wellness Visit (as defined by Medicare) with their doctor. During this visit, you and the patient should develop or update a personal health plan based on the patient's current health and risk factors, and complete a Health Risk Assessment. Answering these questions can help you and the patient develop a prevention plan for staying healthy and getting the most out of the visit. There are three codes that can be billed for these visits: G0402 (Welcome to Medicare—first 12 months in Medicare), G0438 (initial Annual Wellness Visit), and G0439 (subsequent Annual Wellness Visits). For more information, visit **cms.gov** and *search* for "The ABCs of the Initial Preventive Physical Examination (IPPE)" and "The ABCs of the Annual Wellness Visit (AWV)" education materials.

Starting January 1, 2017, participating in these visits is the first step for MVP Medicare members to earn a Wellness Rewards incentive for completing select preventive services. Members will ask the provider to complete and sign a form confirming they have had a Welcome to Medicare or Annual Wellness Visit, a colorectal cancer screening within the recommended Medicare guidelines, and a flu shot for the current flu season. Members are responsible for submitting the information to MVP to receive their reward of a $75 gift card.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the June meeting. 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 **mvphealthcare.com**. To access the BIM, log in to your account and select *Online Resources*, 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 December 1, 2016

Autologous Chondrocyte Implantation, Osteochondral Allograft Transplantation, Osteochondral Autograft Transfer System (OATS): Now covered when medical policy criteria are met. Previously these three procedures were not covered.

Bariatric Surgery: The policy was updated with criteria for subsequent or repeat bariatric surgeries. Previously, these were an exception and a limit of one procedure per lifetime per patient.

Bone Density Study for Osteoporosis (DEXA): There are no changes to the medical policy criteria.

Breast Surgery for Gynecomastia: There are no changes to the medical policy criteria.

Bronchial Thermoplasty: There are no changes to the medical policy criteria. Bronchial thermoplasty remains a non-covered procedure.

Cosmetic and Reconstructive Services: There are no changes to the medical policy criteria.

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

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

Durable Medical Equipment: MVP follows Medicare criteria and guidelines.

Early Childhood Disorders (VT): There are no changes to the medical policy criteria.

Gender Reassignment: The Gender Reassignment medical policy has been updated with the following Medicaid requirements: The requirement that a member be over 21 was removed and signing of form for procedure resulting in sterilization was removed. Letters are required from New York State licensed mental health professionals and are now allowed from a New York certified psychiatric nurse practitioner. Conversion therapy has been added to the exclusions section as not covered.

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

Home Care Services: There are no changes to the medical policy criteria.

Hyperbaric Oxygen Therapy (HBO): There are no changes to the medical policy criteria.

Indirect Handheld Calorimeter: There are no changes to the medical policy criteria.

Inpatient Skilled Nursing Facility (SNF) Services for Medicare Products Only: NEW POLICY The policy follows Medicare criteria for inpatient SNF coverage. For full Medicare language and criteria please refer to the link listed in the medical policy.

Insulin Infusion Pumps: The Insulin Infusion Pumps Policy includes criteria form Interqual, Medicare, American Diabetes Association, and American Association of Endocrinologists. A Medicare exclusion was added in regards to OmniPod disposable drug delivery system, which is not covered for Medicare members.

Investigational Procedures: Sacroiliac Joint Fusion for treatment of low back pain (Ifuse system) and Percutaneous Sacroplasty for sacral insufficiency were added to the policy. Both Sacroiliac Joint Fusion and Percutaneous Sacroplasty are not covered as they are considered investigational.

InterQual Criteria Medical Policies: There is a Medicare variation for spinal cord stimulators which can be used to treat chronic intractable pain.

Knee Arthroscopy: ARCHIVED This policy will be archived effective December 1, 2016.

Orthognathic Surgery: There are no changes to the medical policy criteria.

Prosthetic Devices Eye and Facial: There are no changes to the medical policy criteria.

Repetitive Transcranial Magnetic Stimulation (rTMS): This policy now follows Beacon Health criteria. rTMS services are reviewed by Beacon Health and Primarilink.

Sinus Surgery (Endoscopic): There are no changes to the medical policy criteria.

Medical Policies for Approval Without Changes in August and September 2016

- Artificial Intervertebral Discs-Cervical and Lumbar
- Autism Spectrum Disorders NH
- Breast Reduction Surgery
- Endoscopy/Colonoscopy
- Endovascular Repair of Aortic Aneurism
- Endovenous Ablation of Varicose Veins
- Laser Treatment of Port Wine Stains
- Low Vision Aids
- Oxygen Therapy for the Treatment of Cluster Headaches
- Personal Care and Consumer Directed Services
- Umbilical Cord Blood Banking

Medical Policy Updates Effective December 1, 2016

Amniotic Membrane Transplant for the Treatment of Ocular Conditions: CPT Codes 65778, 65779, 65780, and HCPCS Code V2790 will not require prior authorization effective January 1, 2017.

Capsule Endoscopy: CPT Codes: 91110, 91111, and 91112 will not require prior authorization effective January 1, 2017.

CT Modifier Claim Payment Reduction Notification

MVP is changing how the technical component fees are paid for radiology claims billed with a CT modifier for all lines of business. This change will be effective for January 1, 2017 and subsequent dates of service.

The CT modifier must be used when claims are billed for non-NEMA Standard XR-29-2013 compliant CT scans. CPT codes affected by this change are: 70450-70498; 71250-71275; 72125-72133; 72191–72194; 73200–73206; 73700–73706; 74150–74178; 74261–74263; and 75571–75574. The technical component payment of global procedures billed with the CT modifier will be reduced by 15 percent. Claims billed with the TC and CT modifier and paid per the CMS provider fee schedule/OPPS will be reduced by 15 percent.

More information is available by logging into your account at **mvphealthcare.com** and selecting *MVP Provider Resource Manual* under *Online Resources*. Please refer to Section 15: Payment Policies, Modifier policy.

PHARMACY UPDATES

Pharmacy Medicaid Opioid Edits

Effective October 1, 2016, New York Medicaid Managed Care Members:

- Will only be allowed a maximum of four prescriptions of opioid analgesics in a rolling 30-day period. A clinical prior authorization will be required for prescriptions of opioid analgesics in excess of four prescriptions in a rolling 30-day period.
- Will only be allowed a seven-day supply starter dose for each new prescription of immediate release opioid analgesics.
- Will not be allowed to fill an opioid analgesic if the member has filled buprenorphine (i.e., Suboxone, buprenorphine/naloxone, buprenorphine SL, etc.) within the past 60 days.

Medicaid Mosquito Repellent Coverage

Effective September 1, 2016, MVP will provide coverage for mosquito repellent when prescribed to Medicaid enrollees, with a valid prescription order, who intend to travel to, or return from a Centers of Disease Control (CDC)-recognized area of localized Zika transmission.

New York Commercial/ Exchange Opioid Edit

Effective October 20, 2016, members will only be allowed a seven-day supply starter dose for each new prescription of immediate release opioid analgesics.

Medicare Diabetic Test Strips

MVP prefers OneTouch, Freestyle, and Precision diabetic test strips for Medicare members. Effective January 1, 2017, MVP will require prior authorization for all non-preferred diabetic test strips. Members can receive a new preferred meter free of charge if they are currently using a non-preferred meter. Members can contact the MVP Customer Care Center at the number on the back of their Member ID card for more details on obtaining a new preferred meter.

Office Administered Drugs for Medicare Members

Beginning January 1, 2017, medications ordered from the CVS Specialty Pharmacy and administered in the office for Medicare Advantage plan patients will no longer be billed to the patient's Part B benefit, these drugs will be covered under the patient's

Part D prescription drug benefit. Examples of these medications include Prolia, Xolair, Xgeva, Lucentis, and Eylea. Under the Part D benefit, the amount the patient pays for the drug will change and drug cost will count toward the coverage gap.

Pharmacy Policy Updates Effective January 1, 2017

Crohn's Disease and Ulcerative Colitis, Select Agents

- No changes

Proton Pump Inhibitor Therapy

- Omeprazole-sodium bicarbonate packets will require prior authorization

Viberzi

- New policy

Enteral Therapy New York and Enteral Therapy Vermont

- Medical foods are not covered
- Promactin AA Plus will not require prior authorization

Enteral Therapy New Hampshire

- Policy archived

Gaucher Disease Type 1 Treatment

- Exclusions updated

Pradaxa

- Policy archived

Hereditary Angioedema

- Updated recommended dosing of Ruconest

Cuprimine

- Policy name changed to Chelating Agents
- Syprine will require prior authorization

Hemophilia Factor

- Coagadex, Adynovate, and Kovaltry added to policy

Xifaxan

- 550mg will require prior authorization

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
Afstyla	Hemophilia A
Epclusa-tier 2 for Commercial and Medicaid	Hepatitis C GT-1, 2, 3, 4, 5, or 6
Zinbryta	MS
Vonvendi	Von Willebrand Disease
Xiidra	Dry eye disease

Drug Name	Indication
Bevespi Aerosphere	COPD
Prednisolone-moxiflox-ketorolac ophthalmic solution	Bacterial conjunctivitis
Byvalson	HTN
Obrelis	CHF, MI

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

Nilutamide
Ethacrynic acid
Aripiprazole ODT

Drugs Removed from Prior Authorization

Iressa
Portrazza
Bendeka
Seebri Neohaler
Darzalex
Alecensa
Propel Implant
Utibron Neohaler

2017 Formulary Changes Effective January 1, 2017

The following drugs will be moving from Tier 3 to Tier 2 on the Commercial and Exchange Formularies:

Anoro Ellipta
Breo Ellipta
Flovent-PA will also be removed
Toujeo
Tresiba

MVP HEALTH CARE

PO Box 2207
Schenectady, NY 12301

mvphealthcare.com

get your

HEALTHY PRACTICES™

by email

If you are not already getting *Healthy Practices* by email, sign up today! The email version is easy to share with your entire office.

Simply complete the form at **www.mvphealthcare.com/providerpreferences** to enroll in MVP e-communications.

MVP HEALTH CARE