Vermont

healthy practices

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www.mvphealthcare.com

in this issue

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Healthy Practices
is a bi-monthly publication of the Corporate Affairs Dept.

comments
Write to:
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Healthy Practices newsletter is going green!

In an effort to reduce costs, and further our company commitment to be environmentally responsible, MVP is now offering the option to receive *Healthy Practices* by email.

Email communications allow for easier save and share benefits to newsletter recipients, in addition to the environmental advantages. You can also retain issues with particularly relevant health care topics or news, and effortlessly share this information with your colleagues.

If you would like to opt in to receive *Healthy Practices* electronically, simply email **ecommunications@mvphealthcare.com** with the word *Subscribe* in the subject line.

Radiology Program Updates

As mentioned in previous issues of *Healthy Practices*, MVP Health Care is partnering with CareCore National for management of radiology services as of April 1, 2012 (pending regulatory approval).

Education/Training Opportunities

CareCore National will accept requests for radiology authorizations online and over the phone. MVP and CareCore National have developed a training plan to educate health care providers on how to request authorizations from CareCore National via webinar. Webinars for health care providers in your area took place in early March. If you missed the webinars and would like to receive the slide presentation, please contact your Professional Relations Representative.

Change in validity timespan for imaging authorizations

The time period during which an approved imaging authorization is valid will change from ninety (90) days to forty-five (45) days for authorizations with a date of service 4/1/2012 and beyond.

This applies to any imaging service that as of 4/1/12 requires prior authorization as part of MVP Health Care's updated radiology program and partnership with CareCore National. For a complete list of CPT codes that will require prior authorization as of 4/1/12, log in to your account at **www.mvphealthcare.com** and go to *Online Resources*.

This change ensures consistent prior authorization practices across MVP's service area and also will help ensure that the authorization is approved based on a patient's most up-to-date clinical information.

3D rendering codes

Effective July 1, 2012, MVP will require prior authorization for the following codes:

- **76376** – 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image post processing on an independent workstation (Use 76376 in conjunction with code[s] for base imaging procedure[s])
- **76377** – Requiring image post processing on an independent workstation (Use in conjunction with code[s] for base imaging procedure[s])

3D rendering of CT, MRI, PET or other imaging procedures can be billed; however, prior authorization must be obtained for the procedure codes noted above. If you are billing the above code in conjunction with a code that does not require authorization, an authorization is still required for the 3D rendering codes.

MVP℠ HEALTH CARE

Professional Relations Updates

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 the MVP website **(www.mvphealthcare.com)** and click the *Privacy and Compliance* link in the green bar at the bottom of the home page. If you would like to receive a printed copy of this information, please call MVP:

Vermont 1-800-380-3530, option 4
VMC 1-800-639-3881

Get ICD-10 information on www.mvphealthcare.com

If you haven't done so already, please visit MVP's ICD-10 web page.

To get to the page, visit **www.mvphealthcare.com**, click *Providers*, and then *ICD-10* (right next to *5010*).

We'll use this page to 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.

Be sure to visit this page on a regular basis as we will routinely be adding new ICD-10 information throughout 2012 and 2013.

Please see our ICD-10 FAQs for answers to questions such as:

How is MVP preparing for the ICD-10 conversion?

We have an ICD-10 team that has been working on several aspects of the conversion for some time. Our timeline shows consistent progress toward being fully compliant on October 1, 2013. Our plan includes the necessary changes in system design and development, business processes and policy development, as well as communication and training.

We will collaborate with the medical community to share information and minimize disruption related to the ICD-10 conversion. We have been involved and will continue to be involved in work across the industry, with America's Health Insurance Plans, industry work groups, local health insurance payers and regional medical societies to address transition and implementation issues.

We will continue to align ourselves with the Centers for Medicare & Medicaid Services' direction and industry best practices and will look for opportunities to provide feedback on ICD-10 conversion.

Facility multiple surgery protocol

Beginning with dates of service of April 1, 2012, MVP will begin applying multiple surgical procedure protocol for both inpatient and outpatient hospital and ambulatory surgical center facility claims for all Commercial lines of business, excluding Catamount. This change in protocol will affect claims submitted for surgical services (CPT® codes range 10021–69990) billed on the same date of service.

The claims processing rules for this new protocol, based on existing professional pricing logic for the same services, which consider primary surgical CPT codes, based on highest allowable charges, will be reimbursed at the 100 percent of the allowed amount. All subsequent surgical CPT codes (next highest Allowable Billed Charges) will be paid at 50 percent of the allowed amount.

MVP's *Provider Resource Manual* (PRM) will be updated to add references to this new protocol. Please contact your Professional Relations Representative if you have any questions about this new protocol.

Cancer documentation

Accurate coding of cancer diagnoses is of particular concern to CMS and other reporting agencies.

Documentation clarity is essential to selecting and reporting correct codes. For instance, does the term "history of prostate cancer" mean that the patient no longer has prostate cancer or does it indicate that the patient has on-going prostate cancer that was not diagnosed at the current visit? The answer to that question depends on which provider you ask.

Current ICD-9-CM Coding Guidelines offer direction on neoplasm coding to accurately report whether a patient currently has cancer or whether the patient has a personal history of cancer. The guideline states that three conditions must be met to qualify as a "history of" status:

1) the malignancy has been excised or eradicated from its site,
2) there is no further treatment directed to that site,
3) there is no evidence of existing malignancy at the site. Follow-up visits, annual mammograms, or PSAs do not constitute "further treatment."

Tools such as encounter form diagnosis codes, computer assisted software, and electronic records are helpful, but one can easily be directed to an incorrect code selection based on unclear documentation.

For further information and training opportunities relating to coding and documentation, contact Lynn Gosier at: **lgosier@mvphealthcare.com**.

Caring for Your Older Adult Patients

How your patients respond to Health Outcome Surveys (HOS): what is the physician's role?

The Centers for Medicare & Medicaid Services (CMS) requires health plans to monitor the care our members receive from their health care providers. As we have discussed in previous editions of this newsletter, the CMS Star Ratings include many measures that are associated with care given by the physicians who care for MVP Medicare Advantage (MA) members.

Some of the measures are self-reported by your patients through a survey called the Health Outcome Survey (HOS). The HOS assesses each MA plan's ability to maintain or improve the physical and mental health functioning of its beneficiaries over a two-year period. The initial survey is sent to get baseline information on the patient's perception of their health. The survey is sent to the same patients (if possible) after two years to assess changes in their health status.

The survey includes questions that ask your patients if their PCP has talked to them about physical activity, about their risk of falls and about urinary incontinence. **CMS is expecting that an assessment of these issues is completed and that a treatment plan is in place to improve the quality of life for your patients if any issues are identified.**

The HOS also includes questions about their physical and mental well being. Several questions are asked about their physical and mental health that compares results to how these patients responded to the survey done two years earlier. Assessment of a patient's physical and mental health is a critical part of any office visit.

The CMS star rating for these measures for the last reporting period are as follows:

CMS Measure*	Rochester HMO Members Results	Rochester PPO Members Results	East Region HMO Members Results	East Region PPO Members Results
Monitoring physical activity (discussed physical activity & PCP advised to start, increase or maintain level of exercise or physical activity)	2 stars	3 stars	2 stars	2 stars
Reducing Fall Risk (assess patient's risk of falling & development of a plan to reduce risk of falls)	3 stars	4 stars	2 stars	2 stars
Improving Bladder Control (assess patient for urinary incontinence & received treatment)	3 stars	3 stars	2 stars	2 stars
Improving or maintaining physical health	2 stars	3 stars	2 stars	2 stars
Improving or maintaining mental health	3 stars	NA	3 stars	NA

*Scores are rated 1 to 5 stars with 5 stars being the highest or best rating.

MVP has developed some tools to assist physicians and their office staff that can be utilized for the above assessments.

They can be found in the *Provider QI Manual* on our website. Go to **www.mvphealthcare.com**, click *Provider* and then *Provider Quality Improvement Manual* in the *Quality Programs* section of that web page. The *MVP Adult Preventive Care Guideline* includes a matrix of preventive services recommended for care of the elderly.

Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the September and October meetings. Some of the medical policies may reflect new technology while others clarify existing benefits. All policy updates are listed online in the *Benefits Interpretation Manual* (BIM). Visit MVP online at **www.mvphealthcare.com**. Providers can directly access the online BIM through the *Reference* section of the *Provider* portal. 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.

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 April 1, 2012

Alopecia/Wigs/Scalp Prosthesis

There are no changes to the policy.

Blepharoplasty/Browlift/Ptosis Repair

There are no changes to the policy.

Breast Implantation

Previously the policy referred to certain procedures in conjunction with a cancer diagnosis. Federal and State mandates do not refer to a cancer diagnosis for post mastectomy reconstruction, therefore, under *Indications/Criteria*; reference to a cancer diagnosis has been deleted. The language was changed to read "post mastectomy procedure" to be consistent with the Federal and State mandates.

Breast Reconstruction Surgery

AlloDerm® for post mastectomy breast reconstruction has not shown to provide superior outcomes in peer reviewed literature and is, therefore, considered to be not medically necessary.

Breast Surgery for Gynecomastia

There are no changes to the policy.

Erectile Dysfunction

- Language has been added to clarify diagnostic testing for erectile dysfunction.
- Criteria for penile arterial revascularization have been added.
- A Medicare Variation has been added that penile revascularization of the artery with or without vein graft is considered investigational.

Hearing Aid Services

The MVP Option and Option Family Variation states that audiology examinations and hearing aid services, products, and supplies (Including batteries) are covered.

Hyperhidrosis Treatments

The *Indications* section was updated to include *Age of onset less than 25 years.*

Lenses for Medical Conditions of the Eye

There are no changes to the policy.

Orthotic Devices

The policy was updated with an MVP Option Variation for Orthopedic Footwear, which includes the following:

- orthopedic shoes (oxford, high top, depth inlay, and custom shoes for non-diabetics that are an integral part of a covered leg brace);
- heel replacements, sole replacements, and shoe transfers involving shoes on a brace;
- inserts and other shoe modifications that are on a shoe that is an integral part of a brace which is medically necessary for the proper functioning of a brace; and
- prosthetic shoes that are an integral part of a prosthesis for members with a partial foot amputation.

Penile Implants for Erectile Dysfunction

There are no changes to the policy.

Speech Therapy (Outpatient)

Vermont and New Hampshire Variations were added to reflect the state law mandates that speech therapy is considered medically necessary when it is part of the diagnosis and treatment of Autism Spectrum Disorders (ASDs).

List of Medical Policies reviewed and approved in 2011 for approval without changes in February 2012:

- Dermabrasion
- Indirect Handheld Calorimeter
- Spinal Fusion Lumbar
- Varicose Veins of the Lower Extremities (Surgical Treatment)

Medical policy updates effective May 1, 2012

Radiofrequency Ablation (Rhizotomy) for Chronic Pain

The title has been changed to Radiofrequency Ablation (Rhizotomy) for "Chronic" Pain. Pancreatic cancer and trigeminal neuralgia have been added as indications. Sacroiliac joint/nerve denervation procedures are considered investigational and not medically necessary.

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.

Credentialing Update

New hyperbaric oxygen therapy (HBOT) credentialing criteria

MVP now has credentialing criteria for hyperbaric medicine centers and for physicians providing hyperbaric oxygen therapy (HBOT). Facilities and physicians treating MVP members using HBOT must fully comply with the requirements defined in the MVP credentialing policies and meet the following:

Physicians

Must meet one of the following requirements:

- Board certification in Undersea and Hyperbaric Medicine by the American Board of Preventive Medicine (ABPM) or the American Board of Emergency Medicine (ABEM) ***OR***
- Completion of a 12-month fellowship in Undersea and Hyperbaric Medicine. The fellowship must be accredited by a program recognized by MVP ***OR***
- Documented proof of eligibility to take the ABPM or ABEM Undersea and Hyperbaric Medicine examination ***OR***
- Affiliation with a Clinical Hyperbaric Facility accredited by the Undersea and Hyperbaric Medical Society ***OR***
- Must provide documented proof of the following:

1) completion of a 40 hour course approved by the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society ***AND***
2) one year of active practice in Hyperbaric Medicine with a minimum of 25 percent of the time or 10 hours per week (whichever is greater) spent in Hyperbaric Medicine ***AND***
3) documentation of a minimum of 100 cases treating the disease specific indications approved by Medicare and currently approved by the MVP medical policy

Please note: After July 1, 2013, physicians that do not meet one of the criteria listed in the first four bullet points will no longer meet MVP criteria and will no longer be able to submit claims for HBOT services provided to MVP members.

Facilities:

- The Center must be accredited as a Level 1, 2, or 3 Hyperbaric Treatment Center by the Undersea and Hyperbaric Medical Society ***OR***
- Must be part of an acute inpatient medical-surgical hospital fully credentialed by MVP per the MVP *Hospital Criteria* and the MVP *Credentialing of Organizational Providers* administrative policy ***AND***
- The center must engage at least one physician who meets one of the approval pathways noted on the MVP *Credentialing Criteria for Physicians Providing Hyperbaric Oxygen Therapy*.

Please note: After July 1, 2013, facilities and physicians that have not achieved accreditation will no longer meet MVP criteria, and may no longer submit claims for HBOT services provided to MVP members.

If you would like a credentialing packet or have questions regarding this change, please contact your Facility Contract Manager or your Provider Relations Representative.

UM Update

Financial incentives relating to utilization management policy

It is the policy of all of the operating subsidiaries of MVP Health Care, Inc. to facilitate the delivery of appropriate health care to our members and to monitor the impact of the Plan's Utilization Management program to detect and correct potential under- and over-utilization of services.

MVP's Utilization Management Program does not provide financial incentives to employees, providers, or practitioners who make utilization management decisions that would encourage barriers to care and services.

Utilization management decisions are based only on appropriateness of care and the benefits provisions of the member's coverage. MVP does not specifically reward practitioners, providers, or staff, including Medical Directors and UM staff, for issuing denials of requested care.

Financial incentives, such as annual salary reviews and/or incentive payments do not encourage decisions that result in underutilization.

Quality Updates

Provider Quality Improvement Manual (PQIM) update

Clinical Guidelines Re-endorsed

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

HIV

MVP continues to endorse the New York State Health Department's (NYSDOH) AIDS Institute's Clinical Standards for Adults, Adolescents, Pediatric Care and the prevention of transmission of HIV/AIDS during the perinatal period. The guidelines were developed by the NYSDOH in conjunction with the Johns Hopkins University School of Medicine, Division of Infectious Diseases. The guidelines are available at **www.hivguidelines.org/Content.aspx**.

Hypertension

MVP continues to endorse recommendations from the National Heart, Lung, Blood Institute for hypertension - *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7).* The recommendations can be found at **www.nhlbi.nih.gov/guidelines/hypertension**.

Heart failure in adults guideline

MVP continues to endorse the Institute for Clinical Systems Improvement *Heart Failure in Adults* guideline which can be found at **www.icsi.org/heart_failure_2/heart_failure_in_adults_.html.** Pages 1-3 of the guideline contain an algorithm which is supported by the remaining pages of annotations and evidence.

Paper copies of these recommendations are available by calling MVP's Quality Improvement (QI) department at **1-800-777-4793, ext 2602**. The recommendations will also be available in an update to the *MVP Provider Quality Improvement Manual*.

The current edition of the manual is located on the provider home page of the MVP website at **www.mvphealthcare.com/provider/qim/index.html.**

Pharmacy Updates

Atypical antipsychotic use in depression

For most patients with major depressive disorder, a selective serotonin reuptake inhibitor (SSRI), serotonin norepinephrine reuptake inhibitor (SNRI), mirtazapine, or bupropion is optimal. For patients who have not fully responded to treatment for depression, an initial strategy is to optimize the intensity of psychotherapy and/or maximize the dose of medication, especially if the upper limit of the antidepressant dose has not been reached.

Abilify, Seroquel XR and Symbyax are classified as atypical antipsychotics and have an FDA approved indication for major depressive disorder or treatment-resistant depression. Effective *July 1, 2012*, MVP will require prior authorization for new starts for Abilify, Seroquel XR and Symbyax to ensure that these medications are prescribed for their FDA approved indication or for a use supported in an American Psychiatric Association other than depression. For a depression diagnosis (treatment-resistant or major depressive disorder), members must be receiving psychotherapy, be compliant with antidepressant therapies at maximized doses and have not received a suitable response or are contraindicated. At least two separate trials of adequate dose and duration of standard therapy must be tried.

Compounded prescriptions

Effective July 1, 2012, prior authorization will be required for compounded medications that exceed $250 in cost. Through the prior authorization process, MVP will determine if the compounded product meets our policy criteria for experimental or investigational use.

Where to find pharmacy updates

In addition to this newsletter, pharmacy policy and formulary updates can be found on our website. Go to **www.mvphealthcare.com**, click on *Providers* and then *Medical and Pharmacy Policy Updates* under *References*. Generally, updates are posted monthly.

E-prescribing tip

As you know, e-prescribing helps streamline the prescription process but every so often, a prescription sent electronically may need to be cancelled. It is important to cancel the prescription as soon as possible. For e-prescriptions sent to the Medco Pharmacy, MVP's mail service vendor, if you need assistance in cancelling a prescription, you can call Medco's Physician Service Center at **1-800-411-1665** or contact them through email at **MedcoeRxGroup@medco.com**.

Medication recalls and withdrawals

In the past several weeks, the Food and Drug Administration (FDA) has issued important medication warning, withdrawals and recalls. To obtain more information on these important manufacturer actions go to the Member portal at **www.mvphealthcare.com**. Simply click on *Manage Prescriptions* then *More*. In the left navigation bar, choose *Pharmaceutical News*.

Pharmacy prior authorization updates

Drug specific and general prior authorization forms can be found on our website. Go to **www.mvphealthcare.com**, click on *Providers* then *Forms*. Completing the drug specific forms in full and where appropriate (ARBs, Proton Pump Inhibitors etc.) will ensure that you have provided MVP with pertinent clinical documentation necessary to make a determination. Generally, delays for additional information will be avoided.

Note: All medication prior authorization requests should be submitted in writing. This includes requests for our MVP Option (Medicaid) and MVP Option Family (Family Health Plus) members. For these populations, the "provider prevails" prior authorization clause no longer applies and all requests are reviewed based on clinical criteria as listed in our policies.

Policy updates

Acne Products

- Additional tretinoin products were added requiring prior authorization. Option and Option Family variation excluding tretinoin and adapalene products was added.

Antineoplastic Enzyme Inhibitors

- Caprelsa was added to policy

Cox-2 Inhibitors

- Familial adenomatous colorectal polpys indication was removed. Pradaxa was added as a step qualifier

Dermatologicals for Inflammation

- Language was updated for MVP Option and MVP Option Family lines of business to support formulary status of Elidel and Protopic

Multiple Sclerosis Self-Injectables

- Language referencing Rochester contracts was removed. Additional statement added whereby suspect activity may be referred to the MVP Special Investigations Unit.

Pain Medication

- Butrans was added to the long-acting narcotic step edit with a quantity limit of 4/28 days. Quantity limits were added to long acting tramadol products based on FDA approved dosing. Abstral, Lazanda, Onsolis and Sprix require prior authorization.

Prescribers Treating Self or Family Members

- Language referencing Rochester contracts was removed. Additional statement added whereby suspect activity will be referred to the MVP Special Investigations Unit

Provenge

- New policy requiring prior authorization with criteria including but not limited to: prostate cancer that has metastasized to bone or soft tissue, disease progression following bilateral orchiectomy or after adequate hormone therapy and estimated life expectancy > 6 months.

Quantity Limits

- Statement defining dose optimization was added

Vimovo

- Option and Option Family variation was added

Weight Loss Medications

- Policy was archived due to decreased utilization

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

- Cosmetic Drug Agents
- Psoriasis Drug Therapy
- Patient Medication Safety
- Qutenza
- Select Hypnotics
- Sabril
- Migraine Agents
- Multiple Sclerosis, Select Oral Agents
- Multiple Sclerosis, Self-Injectables
- Physician Prescription Eligibility

Formulary updates for Commercial and Option members

New drugs *(recently FDA approved, prior authorization required, Tier 3, non-formulary for Option/Option Family)*

Drug Name	Indication
Adcetris†	Hodgkin's lymphoma
Conzip	Moderate or moderately severe pain
Erwinaze†	Acute lymphoblastic leukemia
Eylea†	Macular degeneration
Ferriprox	Iron overload
Jakafi	Myelofibrosis
Juvisync	Diabetes and to lower LDL-C
Lazanda	Breakthrough cancer pain
Nucynta ER	Moderate-severe chronic pain
Onfi	Seizures (Lennox-Gastaut)
Orencia SQ+	Rheumatoid arthritis

Generic drugs added to Formulary (Tier 1)

amlodipine/atorvastatin (Caduet)
atorvastatin (Lipitor)
cambamazepine 12hr (Carbatrol)
clobetasol shampoo (Clobex)
eprosartan (Tevetan)
felbamate susp (Felbatol)
fluocinolone (Derma-Smoothe FS)
ketoconazole foam (Extina)
lamivudine (Epivir)
lamivudine/zidovudine (Combivir)
levetiracetam (Keppra XR)
levocetirizine soln (Xyzal)
methyphenidate LA (Ritalin LA caps)
minocycline ER (Solodyn)
morphine sulfate ER (Kadian)
morphine sulfate (Kadian)
olanzapine (Zyprexa)
tramadol ER (Ryzolt ER)

Drugs removed from the Formulary*

Tobradex
Effective 3/1/12
Combivir
Epivir
Lipitor

*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)

Banzel susp	Cuvposa
Lastacaft	Nexiclon XR
Tradjenta[D]	Viramune XR
Xerese	

†Drugs indicated as "medical", when provided in a physician office or outpatient facility, are a covered Medicare Part B benefit and are subject to MVP commercial policies.
+Must be obtained from CuraScript for non-Medicare lines of business
[D]May be covered at diabetic copay for commercial members

Web Updates

New benefit limit web page

MVP is always working on ways to improve our website to give health care providers the information they need to appropriately treat our members. We know that your office often needs to quickly access your patient's benefits, including whether your patient has a deductible (and how much of that deductible has been met), how many physical therapy visits are covered and how many your patient has used, and if your patient has used his or her routine eyewear/eyecare benefits. MVP is now introducing the ability to check the following information, all on a single "benefit limit" web page:

- ***Member Deductible*** – This will show the patient's individual and family deductibles, as well as the amount of the deductible remaining and when the deductible has been met.
- ***Physical Therapy/Occupational Therapy Limits*** – MVP members often have a specific number of physical and occupational therapy visit limits for a benefit or calendar year. You will see how many visits a patient is allowed, and how many have been used to-date.
- ***Member Out-of-Pocket Maximum*** – Some benefit plans have a lifetime or yearly out-of-pocket maximum. You will see detail on your patient's out-of-pocket maximum, including how much has been used toward that limit.
- ***Eyewear and Eyecare*** – Members who have vision benefits are allowed routine care once every year or every two years. You will see your patient's last date of service for routine eyecare and eyewear. You will need to refer to the Benefits Display to determine if your patient's coverage includes eyewear/eyecare every one or two years to determine if your patient is eligible for covered services.

To access the new benefit limit web page for a patient, follow these steps:

- Visit **www.mvphealthcare.com/provider** and log in to your account
- Click on the gray box to go to the *Provider Snapshot* page
- On the *Provider Snapshot* page, click *Patient Inquiry*
- Enter at least 2 of the following member identifiers:
  - 11-digit subscriber/member ID
  - date of birth
  - Social Security Number
  - member's last name (first 2 letters)
- When your patient's information is displayed, click on his or her name in the member eligibility area
- On the member profile screen, scroll down and click on your patient's medical product to go to the benefit limit page.

Note: Only benefit limits that apply to the specific patient you look up will display on the benefit limit web page. For example, if "deductible" is not shown, it indicates that your patient does not have a benefit package that includes a deductible.

Enhancements to online *Benefits Display*

Benefits Display offers you quick and comprehensive online access to your patients' coverage and payment responsibilities.

Latest version just released

MVP updated *Benefits Display* in late February 2012 based on user feedback. Along with some minor formatting enhancements, the latest release includes one important update: for each benefit listed, the "base" benefit will display first, with any "rider" benefit just underneath it. This will enable you to quickly see how a patient's rider(s) affect his or her payment responsibility rather than scrolling down the *Benefits Display* page to check for a rider for each benefit listing.

Important note

When reviewing a patient's payment responsibility, the amount for which the patient is responsible is listed with the first benefit shown within a category. Any other payment responsibilities within that group of benefits will be blank, indicating that they are the same as the first benefit in the group. If there is a difference in payment responsibility for one benefit in the group, it will be indicated in the *Member Responsibility* column with a different cost amount.

What's next

In January 2012, *Benefits Display* became available to all users of MVP's website who have a login account — members, employers, brokers and health care providers — to allow access to benefit information **for members of select products** (the Federal Government plan, the New York State Health Insurance Plan [NYSHIP], the Finger Lakes Consortium and Medicare). MVP continues to work toward making *Benefits Display* available for all of your MVP patients and will announce updates in *Healthy Practices*.

To access the *Benefits Display* for a patient

Log in at **www.mvphealthcare.com/provider,** perform a patient inquiry and select a patient, then go to *Patient Information*. If the patient search is for a member whose health plan is configured for *Benefits Display*, the patient's health plan name in the *Subscriber* and *Policy Details* section will be underlined and blue – a hotlink that will bring up the *Benefits Display*.

MVP HEALTH CARE

P.O. Box 2207
Schenectady, NY 12301

Government Program Updates

MVP Option now covers PERS units, monitoring

As of January 1, 2012, coverage for Personal Emergency Response Systems (PERS) was transferred from Medicaid Fee-for-Service coverage to managed Medicaid plans as a Medicaid Redesign initiative. MVP has chosen American Medical Alert Corporation as our PERS provider for installation of units and monitoring in Dutchess, Genesee, Livingston, Monroe, Ontario, and Ulster counties.

Prior authorization is required for PERS. MVP Option members must be currently receiving authorized personal care services in their home (personal care services also require prior authorization).

Copays for in-office services to Medicare members

During an analysis of claims processing, MVP identified three services for which our system was not applying a copay as per our contract with Medicare: allergy injections, allergy testing and nurse visits. The copay requirement was restored in the system on January 1, 2012. This may affect claims submitted by your office for these services on or after January 1, but will not affect claims prior to that date. Please continue to check each patient's most current benefits on the MVP website to ensure that you collect the appropriate copay or coinsurance for services.