New York

healthy practices™

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IN THIS ISSUE

Radiology program re-design effective April 1, 2012

MVP Health Care recently concluded a review of its radiology management program and found opportunities to improve utilization management and enhance quality. On April 1, 2012, MVP will launch a re-designed radiology program that will be managed by CareCore National, a highly-experienced specialty benefit management company (pending regulatory approval).

As part of the new program, prior authorization will be required for advanced imaging such as magnetic resonance (MRI/MRA), computed tomography (CT), positron emission tomography (PET) and nuclear cardiology. A list of CPT® codes that will require prior authorization for dates of service on or after April 1 is included with this newsletter. An updated billable grouping list will be included in the next issue of *Healthy Practices*.

Because of this change, please be aware that MVP's current online radiology authorization tool (Advanced Diagnostics Management, or ADM, from McKesson®) will be replaced by resources offered by CareCore National. This change will take place prior to April 1 to avoid disruption in your patients' care. Training resources and assistance will be available to help ensure that your practice can transition smoothly from ADM to CareCore web tools. More information will be included in the next issue of *Healthy Practices*.

If you have questions, please contact your Professional Relations Representative.

EDI Updates

5010 Update

- MVP is live on 5010 Eligibility (270/271) and Claim Status (276/277). These transactions are facilitated by Post-n-Track. Please contact them for testing: **1-860-257-2030** or **www.post-n-track.com**
- MVP is live on 5010 Claims (837I/837P) and returning 999 (Acknowledgement) and 277CA (Claims Acknowledgement).
- MVP is live on 5010 Electronic Remittance Advice (835).

Please direct questions to MVP's EDI Services team at **EDIServices@mvphealthcare.com**.

Common 5010 claim errors to avoid

- The Billing Provider's address must contain a physical street address.
- For MVP, all Patients are considered Subscribers when creating an 837. Please ***do not*** use the Patient Loop (2000C/2010CA); also, inserting a member number in this loop is non-compliant. This may result in "Member not Found" claim level rejections.

EDI tips & requirements

- When doing a Claim Status Inquiry (276), remember to use the Rendering Provider and that provider's NPI on Professional Claims. MVP's system is driven by the Rendering Provider. Use of the Billing Provider, when different from the Rendering, will usually result in a Not Found claim.
- When doing an Eligibility Inquiry (270), please note that the patient's address is required by MVP.
- As of January 1, 2012, all MVP IDs will start with an "8." If you see an ID that begins with an "A," please request to see your patient's new MVP ID Card.
- MVP does not send Electronic Remittance (835) to providers via Emdeon. If you are an Emdeon client and want to receive an 835 from MVP, please contact MVP or Post-n-Track to arrange it.
- Currently, MVP does not accept Medicare crossover claims.
- Secondary COB claims can be submitted electronically. For details, visit **www.mvphealthcare.com/provider/documents/secondary-payer-COB-rules.pdf**.

MVP HEALTH CARE℠

David W. Oliker
MVP President & Chief Executive Officer
Healthy Practices is a bi-monthly publication of the Corporate Affairs Dept.

Contacting Professional Relations

MVP Corp. Headquarters	(888) 363-9485
Southern Tier	(800) 688-0379
Central New York	(800) 888-9635
Midstate	(800) 568-3668
Mid-Hudson	(800) 666-1762

Comments

Write to:
Healthy Practices
MVP Health Care, Inc.,
Professional Relations Dept.
PO Box 2207, Schenectady, NY 12301

Emdeon clients

As Emdeon moves to the 5010 standard, it will become especially important that you review the Acknowledgement Report (277CA) coming back to you from MVP via Emdeon for rejected claims. Emdeon will not edit for all 5010 HIPAA requirements, so you may see a higher rejection rate. Please correct these claims promptly and re-submit as soon as possible, since the timely filing clock is still running on those claims.

Attention modem users

With the implementation of 5010, so MVP's support for modems will be ending no later than 1/1/2012. If you currently use a modem to transmit your claims and receive your remittance advice (835) with MVP, please contact your software vendor to discuss switching to Post-n-Track. Claims and remittance advices can be transmitted/received through Post-n-Track at no cost to you. You also may contact Post-n-Track directly at **1-860-257-2030** or MVP EDI Services at **1-800-933-3920, ext. 2239**.

Professional Relations Updates

Automated phone calls for preventive care visits and reminders

MVP will be making phone calls to members to remind them about important preventive care screenings and tips for managing chronic conditions. MVP has partnered with the Eliza Corporation who is able to reach out to a large portion of our membership using automated calls.

This speech activated technology simulates one-to-one conversation and uses a real human voice, not a computer generated one. The purpose of the phone calls is to remind members about the importance of visiting their doctor annually to discuss the following topics if they apply: diabetes management, spirometry testing for COPD, managing rheumatoid arthritis and screening for osteoporosis and breast cancer in women.

JW Modifier Policy

Effective 1/1/12, MVP will implement a new policy for the use of the JW Modifier. This modifier must be used to identify unused drugs or biologicals from single-use vials or single-use packages that are appropriately discarded. This program provides payment for the amount of drug/biological discarded along with the amount administered, up to the amount of the drug or biological indicated on the vial or package label. The smallest vial or package size needed to administer the appropriate dose should be used.

This modifier must be billed on a separate line to enable payment for the amount of the discarded drug or biological. Drug wastage must be documented in the patient's medical record with the date, time, amount wasted and reason for wastage. Upon review, any discrepancy between the amount administered to the patient and the amount billed may be denied as non-rendered unless the wastage is clearly and accurately documented. The amount billed as "wasted" must not be administered to another patient or billed to either MVP or another carrier.

Drug wastage cannot be billed if none of the drug was administered (e.g. missed appointment).

The JW Modifier may NOT be applied to multi-dose vials that have a long shelf life and can be given over multiple days. These are not subject to payment for discarded amounts of drug.

MVP will publish this policy in the *Payment Policy* section of the *Provider Resource Manual* on 12/1/11. *The Provider Resource Manual* can be found at **www.mvphealthcare.com/providers.** Log in and click on *Online Resources*.

Reminder: MVP national alliance with CIGNA

MVP Health Care formed an alliance with CIGNA in 2007 that allows MVP's upstate New York provider network to treat CIGNA members. Please take a few minutes to re-familiarize yourself with how the alliance works, what CIGNA ID cards look like and more by referring to the ***CIGNA Quick Reference Guide*** that is posted to the *Provider* page of the MVP website **(www.mvphealthcare.com)**.

Report suspected insurance fraud/abuse

Each year, fraudulent and/or abusive health insurance claims increase health care costs. To help combat insurance fraud and abuse, MVP's Special Investigations Unit (SIU) uses high-tech software to detect, track, analyze, and report instances of health care fraud, abuse or misrepresentation.

The SIU staff uses STARSentinel™ software to survey and evaluate claims data – including provider/facility history, specialty profiles, common fraud schemes and/or abuse, and claim patterns that differ from past history or peer norms for a given condition or specialty. STARSentinel™ identifies suspicious claims for:

- Falsification of procedure codes
- Falsification of diagnosis codes
- Manipulation of modifiers
- Up-coding
- Over-utilization of diagnostic procedures and tests; and
- Over-utilization of treatment modalities.

The SIU staff also works closely with state agencies responsible for identifying and investigating potential insurance fraud and/or abuse, other insurance companies, and law enforcement agencies. MVP also relies on our participating facilities, providers and their office staff to help us fight insurance fraud and/or abuse.

Please report any suspicious activity by calling MVP's Special Investigations Unit (SIU) toll-free at **1-877-TELL-MVP (1-877-835-5687)**. All information is kept confidential.

Reminder: MVP phone line upgrade

The first phase of MVP Health Care's phone line upgrade launched on September 21, with new menu options and interactive voice response options for our most-used phone lines that enable callers to speak their choices to navigate our phone menu.

The following phone numbers were part of the recent IVR phone system upgrade.

- Customer Care Center for Provider Services: **1-800-684-9286**
- Utilization Management: **1-800-568-0458**

MVP also upgraded many of its Customer Care Center phone lines called by our members.

A listing of the new menu options, showing the options that are available under each category, is included here for your reference.

New Call Menu Options Customer Care Center for Provider Services (1-800-684-9286) and Utilization Management (1-800-568-0458)

MVP's new interactive voice response system will lead you through these options when you call (after providing your NPI, the member's identification number and date of birth).

- Eligibility
- Benefits
- Authorizations
  - imaging
  - inpatient/outpatient
  - durable medical equipment
  - home services/skilled nursing
  - pharmacy
  - referrals
  - main menu
  - other
- Claims
  - behavioral health
  - claim status
  - dental
  - mailing address
  - main menu
  - other
- Other
  - coordination of benefits
  - mailing address
  - referrals
  - main menu
  - other

NOTE: you may press the star button twice (**) at any time to hear prompts for using touchtone entry rather than the interactive voice response system.

Web Updates

Not yet registered for an online account?

By registering for an account at **mvphealthcare.com** allows you a fast, easy way to get information you need about your MVP patients, our policies and procedures, newsletters and much more. If your practice has Internet access, visit **www.mvphealthcare.com/provider/register.html** to set up accounts for your staff. New features are constantly in development to make your online account a valuable tool for your practice!

Update your provider account profile

If your online account profile includes an outdated or personal email address, take a moment to update it with your current business email address. As MVP continues to explore ways of getting you the information you need via the technology you prefer, your valid email address and profile information will enable you to quickly and easily be part of our advancements! You can update your email address, password and security question at any time by clicking the *Change Profile* link (under your name) just after logging in at **www.mvphealthcare.com/provider.**

UM Updates

Potential HIPAA issues when submitting EOB/EOP to support payment of claims

There are times when MVP requires providers to submit claims with an *Explanation of Benefits* (EOB) or *Explanation of Payment* (EOP) to process a claim. MVP recently noticed that providers are submitting EOB/EOPs for MVP members with other members' protected health information still visible. This may be considered a HIPAA violation. We are asking for your cooperation in maintaining the protected health information of your patients and our members.

Please be advised that when you submit a claim to MVP with an EOB/EOP as an attachment, you need to suppress or black out all other information that does not pertain to the member about which you are inquiring. This will ensure that providers and MVP are keeping our members' protected health information secure. Thank you for your assistance.

Facets Explanation of Payment (EOP)/ Remittance Enhancements

EOP/Remit will have a new look effective November 21, 2011. (This applies to checks that have a paid date of 11/20/2011 and after.)

Updates and enhancements were made based on feedback from providers and facilities. The overall goal was to make the EOP more user-friendly. Most of the content remains the same. The first thing you will notice is the page orientation which went from vertical to horizontal. Claim line numbers have also been

included and shading has been removed. For remits with a check amount of zero there will no longer be a check on page one showing a zero amount. The first page will contain mailing information only.

Other enhancements are listed below:

Previous Column Headings	Updated Column Headings
Eligible	Allowed
Net Payable	Paid
Services	Rev (Revenue Code)
	Proc-M (Procedure Code-Modifier)
	APC-SI (Ambulatory Payment Classification-Status Indicator)
New Column Headings	
PD DRG	Paid DRG
POS	Place of Service
NPI	National Provider Identification
Taxonomy	Taxonomy
Pt. Resp.	Patient Responsibility
SOI	Severity of Illness
ROM	Risk of Mortality
Med Rec	Medical Record
DOB	Date of Birth

The APC OCE Editor Version and message will print below any claim with an OCE denial. AN APC OCE edit is an ambulatory payment classification, outpatient code edit.

(The EOP example does not display OCE edit information.)

Example OCE Edit remarks:

APC Outpatient Coder Editor: (OCE) v. 104:
(Consolidated Due to Claim Adjustment)

Line# 001 (Y40) OCE9-Non-covered for reasons other than statue

Line# 003 (Y44) OCE15-Service unit out of range for procedure

Multiple (Y76) OCE47-Service is not separately payable

An example of the new EOP is below. *(The Batch Number at the top of the EOP example is for MVP use only.)*

Clinical editing knowledge pack

In the previous edition of *Healthy Practices*, MVP published an article regarding a new clinical editing knowledge pack which would be effective on January 1, 2012. The implementation date of this initiative has changed to April 2012. More information on the knowledge pack will be included in future versions of *Healthy Practices*; however, here is a recap:

McKesson ClaimsXten ensures that payment policies are applied consistently while providing additional transparency for providers. The sources of ClaimsXten's correct coding standards include but are not limited to:

- National Correct Coding Initiative (NCCI)
- American Medical Association (AMA)
- Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)

These standards are currently used for facility and non-facility claims.

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.

MVP HEALTH CARE

[redacted]
ADMINISTERED BY MVP SELECT CARE, INC.
P.O. BOX 1434
SCHENECTADY, NY 12301

5 _____ Batch #
[redacted]

Page 3 of 4
Check Date: 08/24/2011
Check Number:
Check Amt: *****$1,076.00
Check Ref ID:
Payee: 0214

PATIENT: [redacted]
PT ACCT: NEW
DOB:
MBR ID:
MED REC:
CLAIM:
ROM:
PD DRG: SOI: NEW

Ln#	Dates of Service	POS	Proc-M	Rev	APC-SI	Qty	Billed	Allowed	Cont-Dis	Withhold	Adj COB	Patient Responsibility Co-Pay	Co-Ins	Ded	Total Pt Resp	Paid	EXP Code
016	07/22/11 to 07/22/11		87491	0310		1	150.00	0.00	150.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
017	07/22/11 to 07/22/11		87591	0310		1	150.00	0.00	150.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
018	07/22/11 to 07/22/11		76830-TC	0402		1	898.00	0.00	898.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
019	07/22/11 to 07/22/11		76856-TC	0402		1	741.00	0.00	741.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
020	07/21/11 to 07/21/11		36000	0450		1	202.00	1001.00	-799.00	0.00	0.00	100.00	0.00	0.00	100.00	901.00	
021	07/21/11 to 07/21/11		99284-25	0450		1	202.00	0.00	202.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	PHP
			Claim Total:				3339.00	1001.00	2338.00	0.00	0.00	100.00	0.00	0.00	100.00	901.00	

Medical policy updates effective December 1, 2011

Autologous Chondrocyte Implantation (ACI)

Autologous Chondrocyte Implantation (ACI) remains not covered. There are no changes to this policy.

Breast Reduction Surgery (Reduction Mammaplasty)

The Indications/Criteria section now states that the minimum amount of breast tissue (in grams) to be removed is determined by the member's body surface area. The policy was updated to include the Schnur sliding scale. There is also a web link in the policy to assist with determining the body surface area as it relates to the Schnur sliding scale link

Chemosensitivity & Chemoresistance Assays

ChemoFX®, Fluorescent Cytoprint Assay and Human Tumor Stem Cell Drug Sensitivity Assays are considered investigational and therefore, are not covered.

Compression Stockings

The policy has been updated to reflect recent changes in Medicaid criteria.

Continuous Glucose Monitoring

The policy criteria was updated to state that 72 hour glucose monitoring will be covered in members with poorly controlled diabetes despite evidence of optimized diabetic treatment as indicated by clinical situations listed in the policy. Recurrent ketoacidosis has been added as an indication.

Durable Medical Equipment

The policy follows Medicare criteria and includes prosthetics and orthotics. The following language "select medical supplies, including diabetic supplies, should be billed through the pharmacy benefit manager under the member's pharmacy benefit" was included in the *MVP Option* and *MVP Option Family Variations* section.

Genetic Counseling & Testing

There are no changes to this policy.

Genetic Testing (BRCA Testing)

The policy title has been changed to "BRCA Testing". The BRCA 1, BRCA 2, and multi-site BRCA 3 testing follows the 2011 NCCN Guidelines.

Hip Surgery (FAI)

Hip Surgery (FAI) remains not covered. There are no changes to this policy.

Home Prothrombin Time Monitoring

There are no changes to this policy.

Hospice Care

The *Variations for MVP Option Child* and *Option Family* have been updated. *MVP Option Child* includes language that for children less than 21 years of age, medically necessary curative services are covered while receiving hospice care. *MVP Option Family* includes language that for children 19 to 21 years of age, medically necessary curative services are covered while receiving hospice care.

Laser Treatment of Port Wine Stains

Language has been included to the Indications/Criteria section to clarify that laser treatment of warts is considered medically necessary when there is documentation in the medical record that the patient "has had complications from conventional therapy" as well as failure of conventional therapy.

MRI Breast

The policy Exclusions section now states that there is insufficient evidence in the peer-reviewed literature that computer-aided detection of Breast MRI results in proven beneficial outcomes and is, therefore, considered investigational and not covered.

Oxygen Therapy for the Treatment of Cluster Headaches

There are no changes to this policy.

Personal Care Services for MVP Option: NEW POLICY

This is policy is for Option products only. The policy outlines the coverage criteria for personal care services for Option members. It follows the Medicaid mandate. Prior authorization is required.

Platelet-rich Plasma Injections: NEW POLICY

This policy addresses platelet-rich plasma injections. Platelet-rich plasma injections are considered investigational and therefore, are not covered.

Prosthetic Devices External (Eye & Facial)

There are no changes to the policy. The policy follows Medicare criteria.

Prosthetic Devices (Upper & Lower Limb)

The policy title has been changed to include the upper limb. Indications and criteria for the upper limb have been added which follow Medicare criteria. The lower limb indications and criteria have been updated to reflect Medicare criteria.

Umbilical Cord Blood Banking: NEW POLICY

Collection and storage of cord blood from a neonate may be considered medically necessary when criteria are met. Prophylactic collection and storage of umbilical cord blood for an unspecified future use for an autologous stem cell transplant is considered not medically necessary.

Wheelchairs (Electric) and Power Scooters

The policy has been updated to include the recent changes to Medicare criteria regarding weight requirements.

Yttrium-90 Microspheres for the Treatment of Liver Cancer

The policy has been updated to include criteria for additional treatment under Indications/Criteria section (i.e., repeat treatment of a single lobe and treatment of additional lobes).

List of medical policies reviewed and approved in 2010 for approval without changes in September and October 2011

- Biofeedback
- Bone Growth Stimulator
- Burn Garments & Lymphedema Sleeves
- Cochlear Implants & Osseointegrated Devices
- Cosmetic & Reconstructive Surgery
- CT Chest/Small Pulmonary Nodules Follow-up
- Intensity Modulated Radiation Therapy (IMRT)
- Prophylactic Mastectomy/Oophorectomy
- Ventricular Reduction Surgery

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.

Hepatitis A and B vaccine update

MVP will continue to allow CPT codes 90632 – Hepatitis A vaccine, adult dosage, and 90746 – Hepatitis B vaccine, adult dosage, to be billed separately when warranted, and will no longer automatically bundle the two to the combined code of 90636.

Please remember that, according to the *MVP Medical Policy on Immunizations Childhood, Adolescents, and Adults:*

Indications for childhood and adolescent immunizations follow recommendations of the American Academy of Pediatrics (AAP). The official recommendations of the United States Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services, the Advisory Committee on Immunization Practices (ACIP) and the United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC) will be considered for childhood, adolescent and/or adult indications. Permissive recommendations of the Advisory Committee on Immunization Practices (ACIP) are not considered medically necessary and, therefore, are not covered. In addition, immunizations for travel purposes, employment, or college entrance are excluded from coverage.

Caring for Your Older Adult Patients

New educational brochure aimed at reducing falls

MVP recently produced a new brochure for our Medicare members to help them reduce their risk of falling and fall-related injuries. In it, we urge members to talk you, their doctors, to assess their risks, create a plan to reduce those risks and then put that plan into action. We have even included a checklist of key discussion points that we hope you will be seeing in members' hands when they visit you! We have posted the brochure online for your reference. Visit the *Provider* page of our website **(www.mvphealthcare.com)** and click on the *Fall Prevention Brochure* link in the *Reference* section.

Drugs with serious side effects for older adults

The Centers for Medicare & Medicaid Services (CMS) is monitoring the prescribing of high-risk medications in the elderly as a patient safety measure and reporting this information to Medicare Advantage (MA) Health Plans. CMS identifies MA plan members who have received at least one prescription for a drug with a high risk of serious side effects in the elderly, when there may be safer drug choices. The list of medications was first developed by the National Committee for Quality Assurance (NCQA) and then adapted and endorsed by the Pharmacy Quality Alliance (PQA) and the National Quality Forum (NQF).

The list of medications is available on the CMS website. Visit **www.cms.gov** and click *Medicare*. Choose *Prescription Drug Coverage – General Information*, then *Part D Performance Data*. In the *Downloads* section, click on *2012 Part C & D Medicare Plan Ratings Data* and then the *2012 Plan Ratings Technical Notes and Fact Sheet* folder. Within that folder, select the *HRM* (high risk medication) list.

Remember to use eDispense for Zostavax® and other Part D vaccines

You can help make getting vaccines administered in-office, such as Zostavax, less stressful for your older adult patients by using the eDispense Part D Vaccine Manager (a product of Dispensing Solutions, Inc.) to submit claims so they don't have to.

eDispense provides physicians with easy, real-time claims processing for in-office administered vaccines. Enrollment in eDispense is FREE; once enrolled, your office can verify members' real-time eligibility and benefits, advise members of their appropriate out-of-pocket expense, submit vaccine claims electronically and receive real-time reimbursement information.

How to enroll

- Complete the one-time online enrollment process at **www.enroll.edispense.com**
- Select an authorized staff member who is most likely to be the primary user of the system to enroll the practice. This person should be prepared to provide the following information about the practice:
  - tax identification number
  - national provider identifier(s) (NPI)
  - Medicare ID number
  - Drug Enforcement Administration (DEA) number
  - state medical license number

Important notes about eDispense

- When using the eDispense Part D Vaccine Manager to file a Medicare Part D vaccine claim, physicians will be reimbursed according to MVP Health Care's reimbursement schedule, less the member's copay.
- It is important to note that the member's copay is not always a flat dollar amount. It could be a percentage copay or even full price depending on where the member is in their Part D pharmacy benefit (for example: if a member is in their deductible phase or coverage gap, they could be responsible for 100 percent of the cost for the vaccine and its administration).
- eDispense cannot be used to bill the administration and cost of Medicare Part B covered vaccines (e.g. influenza vaccine, pneumococcal vaccine, or Hepatitis B vaccine for high or intermediate risk individuals).

Questions?

For questions related to eDispense enrollment and claims processing, call Dispensing Solutions' customer support center at **1-866-522-3386** (EDVM).

Pharmacy Updates

Enteral Therapy

Effective 10/1/2011, enteral nutrition for non-Medicare members must be obtained at an MVP-participating pharmacy and adjudicate through the MVP pharmacy benefits manager (PBM). Copays and/or coinsurance are subject to the member's enteral product benefit. Home infusion vendors that also participate with MVP as a pharmacy provider must bill using a valid NDC/UPC product number. Enteral products indicated for inherited diseases of metabolism (ie: PKE, MSUD) will adjudicate without prior authorization. All other products require prior authorization to determine medical necessity as established in MVP policy.

Pharmacy Policy and Formulary update effective December 1, 2011

Alpha-1 Antitrypsin Inhibitor Therapy

- Glassia was added to the policy

Antineoplastic Enzyme Inhibitors

- Indications for Afinitor and Sutent were updated

Erythropoietic Agents

- Indication language updated for anemia in HIV infected members
- Medicare variation updated to include diagnosis of SLE as a prerequisite for EPO treatment

Hepatitis C Protease Inhibitors

- New policy establishing prior authorization criteria for Victrelis and Incivek. Criteria include but not limited to diagnosis of HCV genotype 1 infection, treatment naïve with at least one other risk factor for poor prognosis or prior relapse, partial response or null responders to prior peginterferon and ribavirin therapy. Medication must be prescribed by an infectious disease physician, gastroenterologist or hepatologist.

Myelodysplastic Syndrome

- Language for Vidaza and Dacogen was updated to correspond to NCCN algorithm

Osteoporosis

- Criteria updated to reflect Reclast or Prolia can be used after failure on oral bisphosphonates and are preferred over Boniva IV.

Pharmacy Programs Administration

- Language was added to reflect specifics to the Option and Option Family benefit MVP administers as of October 1, 2011. Highlights include a specific formulary that differs in select classes from the MVP commercial formulary and the availability of a transition supply of medication. Also included was information on blood factors (ie. Factor VIII) and select injectable anti-psychotics which remain carved out to Medicaid fee-for-service.

Pradaxa

- This new policy establishes prior authorization criteria that includes diagnosis of atrial fibrillation, failure on warfarin and one risk factor for stroke.

Thalidomide & Thalidomide Derivatives

- Added definition of active, symptomatic multiple myeloma and updated therapy table based on review of NCCM guidelines

Xgeva

- New policy that defines step therapy through injectable bisphosphonates prior to Xgeva

The following policies were archived:

- Select Biologic Chemotherapy Agents

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

- Actimmune
- Chronic Hepatitis C
- Formulary Exception for Non-Covered Drugs
- Ixempra
- Mozobil
- Tysabri for Multiple Sclerosis

Formulary updates for Commercial members

The MVP Formulary is updated after each Pharmacy and Therapeutics Committee meeting. The most current version is available online at **www.mvphealthcare.com**. Simply visit the site's *Provider* section and under *Pharmacy*, click on *Formulary*. The MVP Formulary can be downloaded to a PDA device from **www.epocrates.com**. There is a link to ePocrates® on the MVP Web site.

New drugs† *(recently approved by the FDA, prior authorization required, Tier 3)*

Drug Name	Indication
Arcapta Neohaler	COPD
Brilinta	Acute coronary syndrome
Complera	HIV-1 infection
Gralise	Post-herpetic neuralgia
Viibryd	Major depressive disorder
Xarelto	Prevention of DVT

Generic drugs added to Formulary (Tier 1)

alfluzosin
bromfenac ophth
Camrese (generic Seasonique)
levetiracetam SRfelbamate

Drugs removed from prior authorization† *(all medications are non-formulary, Tier 3 unless otherwise noted)*

Natroba	Safyral	Moxeza
Ofirmev†	Xiaflex†	

Drugs removed from the Formulary* (change from Tier 2 to Tier 3) effective 12/1/2011:

Seasonique (for Option and Option Family)

**Affected members will receive a letter if further action is required (i.e. contacting the prescriber for a formulary alternative)*

†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.

ST Subject to step therapy

QL Subject to quantity limits

+ CuraScript mandatory

Medication recalls and withdrawals

In the past several weeks, the Food and Drug Administration (FDA) has issued important medication warning, withdrawals and recalls. Highlights of the FDA activity include:

On September 15, 2011, Qualitest Pharmaceuticals issued a voluntary, nationwide, retail-level recall of multiple lots of oral contraceptives. The recall is being implemented because of a packaging error, where select blisters were rotated 180 degrees within the card, reversing the weekly tablet orientation. As a result of this packaging error, the daily regimen for these oral contraceptives may be incorrect and could leave women without adequate contraception, and at risk for unintended pregnancy. Pharmacies are being instructed to contact consumers who have received affected product.

The recall is effective immediately and includes the following products:

- Cyclafem™ 7/7/7
- Cyclafem™ 1/35
- Emoquette™
- Gildess® FE 1.5/30
- Gildess® FE 1/20
- Orsythia™
- Previfem ®
- Tri-Previfem®

MVP sent letters to 441 members advising them to contact their pharmacy to see if they have an impacted product.

Quality Updates

Chlamydia: Educate your female patients about the "silent" STD

Chlamydia is a common sexually transmitted disease (STD) caused by the bacterium, *Chlamydia trachomatis*. Even though symptoms of Chlamydia are usually mild or absent, if untreated, Chlamydia infections can progress to serious reproductive and other health problems with both short-term and long-term health effects. Chlamydia infection and the damage that it causes is often "silent."

Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. According to the Centers for Disease Control and Prevention (CDC), in 2009, 1,244,180 Chlamydia infections were reported to the CDC across the United States. Even in consideration of these staggering statistics, under-reporting of Chlamydia infection is substantial because most people infected with Chlamydia are not aware that they are infected and thus do not seek testing.

Results from the 2011 Healthcare Effectiveness Data and Information Set (HEDIS) for measurement year 2010 indicate that half or more of young, at-risk women living in New York State and Vermont enrolled in MVP Commercial HMO/POS products are still not being tested for Chlamydia infection (MVP Commercial HMO members age 16 to 24 years without a Chlamydia test during 2010 is 49.5 percent. MVP Commercial HMO Vermont members age 16 to 24 years without a Chlamydia test during 2010 is 56.6 percent).

The CDC recommends yearly Chlamydia testing of all sexually active women age 25 years or younger, older women with risk factors for Chlamydia infections (those who have a new sex partner or multiple sex partners), and all pregnant women. An appropriate sexual risk assessment by a health care provider should always be conducted and may indicate more frequent screening for some women. Once diagnosed, Chlamydia can be easily treated and cured with antibiotics. You can help prevent pelvic inflammatory disease, infertility, ectopic pregnancies, and other complications for your female patients. Test all sexually active women ages 16 to 25 years for Chlamydia infection. Teach your patients about the disease, its complications, and how they can be tested for Chlamydia infection.

To help you educate your patients, MVP Health Care has developed a *Risky Teen Behaviors* educational brochure. The brochure deals with teen risk factors such as, nutrition and exercise, smoking, drugs and alcohol, depression and pregnancy and sexually transmitted diseases, including Chlamydia.

If you have any questions or would like copies of the *Risky Teen Behaviors* brochure to share with your patients, contact the Quality Improvement Department at **1-518-388-2602**. These materials also may be downloaded from the Physician Quality Improvement Manual accessible through the MVP website at, **www.mvphealthcare.com/provider/qim/documents/risky_teen_brochure.pdf.**

Excerpts taken from the CDC 'fact sheet' on Chlamydia. Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of STD Prevention, August 17, 2011

MVP adheres to the Americans with Disabilities Act

MVP Health Care assists members with different cultural or linguistic needs. MVP has developed a brief overview of the Americans with Disabilities Act for its internal use that also includes information on diversity and sensitivity and the services that MVP offers to member who have a language barrier or who are visually or hearing impaired. To request a copy of this information, please contact the QI Department at **1-800-777-4793, ext 2602.**