West (Roch/Buf)

# 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*.

With the launch of this new program on April 1, please be aware that the practice of allowing authorizations without clinical review (known as Goldcarding) will be discontinued.

To alleviate some of the added work associated with this change, we are pleased to announce that your practice can begin utilizing CareCore National's online radiology authorization tool. This change will take place prior to April 1 to avoid disruption in your patients' care. Training resources and assistance will be provided to help you get started with online authorizations, which will streamline the request process and minimize additional administrative requirements for you and your staff. 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
Buffalo (716) 839-1366, x1000
Rochester Call your representative or Provider Services at (800) 999-3920

**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**.

# Medicaid Updates

## Medicaid changes affect MVP Option and MVP Option Family

### Pharmacy – effective 10/1/11

As part of Medicaid Redesign efforts, pharmacy coverage, including medical supplies, is now provided under MVP's Option and Option Family plans.

- MVP has developed a new formulary called the *MVP Option and Option Family Formulary*. A copy is posted on the MVP website at **www.mvphealthcare.com/provider/pharmacy.html**
- Use the same prior authorization process you currently use for MVP members to obtain an authorization for MVP Option and MVP Option Family members.
- When submitting a prior authorization, all supporting clinical documentation must be included. This will allow MVP to process the authorizations in a timely manner.
- MVP issued all MVP Option and MVP Option Family members new ID cards prior to 10/1/11 with the pharmacy coverage information included on the back of the card.
- There will be no change in the coverage of medical supplies.
- The authorization and formulary process is the same that is required for all MVP Managed Care Plans. Please be sure to review the MVP Option and MVP Option Family formulary as it varies from MVP's other formularies.

### Pharmacy Letter of Disruption

- Providers received a "letter of disruption" highlighting the MVP Option and MVP Option Family members that have been prescribed medications that will require an authorization from MVP.
- Members also received a "letter of disruption" if they are taking a drug that is not on the formulary, that requires prior authorization, or not using an MVP participating pharmacy.
- When Providers receive this letter, please reach out to the member to make changes as needed.
- **Members may receive a one time temporary fill after 10/1/11 of a medication that requires authorization or is not on the formulary.** Once this temporary fill has been given, both the member and the provider will receive a follow-up letter indicating that they will not receive any additional fills for that medication until an authorization request has been submitted and approved by MVP. ***Prescribing practitioners should take action as soon as possible and either change members to an MVP covered medication or request an authorization from MVP so that members will not have a disruption in therapy.***

More information is available in the *Pharmacy Section* of MVP's *Provider Resource Manual*.

### REVISED: Coverage for Physical Therapy/ Occupational Therapy/Speech Therapy Visits

Effective 10/1/11, the New York State Department of Health implemented a change in benefits for MVP Option (Medicaid) and MVP Option Family (Family Health Plus) for physical therapy, occupational therapy and speech therapy visits.

As stated in the September/October 2011 *Healthy Practices* newsletter, a limit of 20 visits for these services will be implemented. This coverage change reflects the addition of a limit to these services for MVP Option and a limit to speech therapy visits for MVP Option Family. MVP Option Family currently has a 20 visit limit for physical and occupational therapy visits.

However, based on recent updated information from NYS, the new benefit limits will not be counted retroactively to 1/1/11; the benefit count began on 10/1/11.

Explained below is the revised covered benefit for these products:

- Each MVP Option member will be allowed 20 visits for each service during the time period of 10/1/11 through 12/31/11. (Services received from 1/1/11 through 9/30/11 will not be applied to the 20 visit limit for 2011.)
- Each MVP Option Family member will be allowed 20 speech therapy visits during the time period of 10/1/11 through 12/31/11. Physical and occupational therapy visits will be counted from 1/1/11, as is currently the case.
- For the time period of 1/1/12 through 12/31/12, each member will be allowed 20 visits for each service.

New York State has implemented a few **exceptions**; the benefit limits **will not** apply to:

- Dependents under age 21
- Members with traumatic brain injury
- Members who have been determined to be developmentally disabled by the Office for People with Developmental Disabilities (OPWDD)
- Services rendered in an inpatient setting, skilled nursing facility or through a certified Home Health Agency

### On August 1, 2011, MVP assumed responsibility for the Medicaid Restricted Recipient Program

On March 31, the New York State 2011-2012 budget was passed, including a cost savings program titled Medicaid Redesign. Beginning August 1, 2011 the management of Medicaid's fee-for service Restricted Recipient program was transferred to managed care health plans including MVP Health Plan, Inc. (MVP).

Members identified as restricted recipients are assigned to specific health care providers for treatment. Usually, these members are assigned to specific pharmacies or physicians because of evidence of abuse or fraudulent behavior.

Since August 1, MVP has upheld current restrictions put in place by the Office of the Medicaid Inspector General (OMIG). Moving forward, MVP will be responsible for identifying members

that have abusive or fraudulent patterns and restricting their access to certain health care providers for their care.

Therefore, when treating MVP Option members, please keep these important things/processes in mind:

- If a member has a restriction and you are not the health care provider that has been assigned to care for the person, you will not receive payment for any services you may render.
- The restricted member must go to their assigned health care provider for treatment. Members in a restricted status have been told which provider they can go to. They are notified in writing, and the provider they are assigned to is told as well.
- To avoid non-payment of services to restricted recipients, you should verify if an Option member is a restricted recipient.
- To do so, please continue to verify eligibility by using MVP's website **(www.mvphealthcare.com)**, using the MVP ID number (not CIN) presented on the ID card. MVP's website will inform you if the member is restricted and instruct you to call the Customer Care Center for Providers for additional information on the restriction. Doing so will help ensure that the member has coverage for the date of service and that the member is eligible to see you.

We **strongly recommend** you follow the above steps for all Medicaid members. If you currently treat Medicaid members, the Medicaid Restricted Recipient Program may not be a new process for you. What has changed is that MVP and other health plans are now managing the program and not Fee-for-Service Medicaid. MVP is working closely with the New York State Department of Health and the Office of the Medicaid Inspector General to obtain more information about restricted recipients, and administration of the program. We will keep you informed about changes that affect you.

# Professional Relations Updates

## Upcoming changes for MVP Medicare and Commercial members

Beginning January 1, 2012, MVP Health Care will maintain all Preferred Gold (Medicare), Commercial and self-insured (ASO) members on its Facets system, completing the transition of all membership to a single claims management platform. MVP's Option (Medicaid) members were already moved to the Facets system this year.

Membership that will transition to the Facets system for January 1 belong to the following plans:

- Preferred Gold HMO
- GoldValue HMO
- GoldAnywhere PPO
- Preferred EPO and PPO
- USA Care PPO
- TriVantage EPO
- MVP Preferred High-Deductible plans
- Self-insured (ASO) plans administered by MVP

### Following is a list of changes that you'll see:

**Member ID numbers will change as of January 1, 2012**

With the transition to Facets, the member ID# will be a 9-digit number beginning with "8." Currently, these members have a member ID beginning with "A."

Members will receive a mailing in mid-December which will include a new ID card with their new ID number. We will remind members to show this card at their next visit. Images of Facets ID cards (recently updated) were included in the September/October issue of *Healthy Practices* and also appear in the updated *Plan Information* section of MVP's *Provider Resource Manual* (PRM) effective November 1.

**New ID required on claims and authorizations**

You will need to use the new ID number that begins with "8" to submit claims or request authorizations for these members starting January 1, 2012.

**Authorizations and case management**

All authorizations and case management that begins in 2011 and will continue in 2012 will remain open, so there will be no need to resubmit requests for them.

**Accessing member information**

- Member Information for all MVP members is available when you log in to MVP's web portal for health care providers **(www.mvphealthcare.com/provider)**.
- By using the new single sign-on, you will be able to access information for all MVP members regardless of their member ID number in 2011 or 2012.
- To view member eligibility information, you can search by name and date of birth or the new ID number beginning with "8." If you need to access information for a date of service before 1/1/2012 for a member whose ID number has changed, enter the old member ID number or search by member name and date of birth.

**MVP Health Care Member Inquiry**

| Date of service **BEFORE** 1/1/2012 | Date of Service on or **AFTER** 1/1/2012 |
|---|---|
| **Search by Member Name and Date of Birth** | |
| Select Member ID beginning with A | Select Member ID beginning with 8 |

We will continue to keep you informed of updates with FastFaxes, during office visits by our Professional Relations representatives, and during upcoming provider/facility meetings.

## 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*.

### *In-Office Procedure* list effective January 1, 2012

The use of the *2011 In-Office Procedure* list which was approved by the Quality Improvement Committee (QIC) will be effective January 1, 2012.

Coverage for in-office procedures is limited to the in-office place of service. Claims submitted with a place-of-service other than in-office will be denied unless prior authorization is obtained.

The *2011 In-Office Procedure* list is located on the MVP website at **www.mvphealthcare.com/provider/documents/in-office-procedure-list.pdf.**

***The in-office list is updated annually and you will be notified in advance when the 2012 list will be available.***

### 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)**.

# 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.

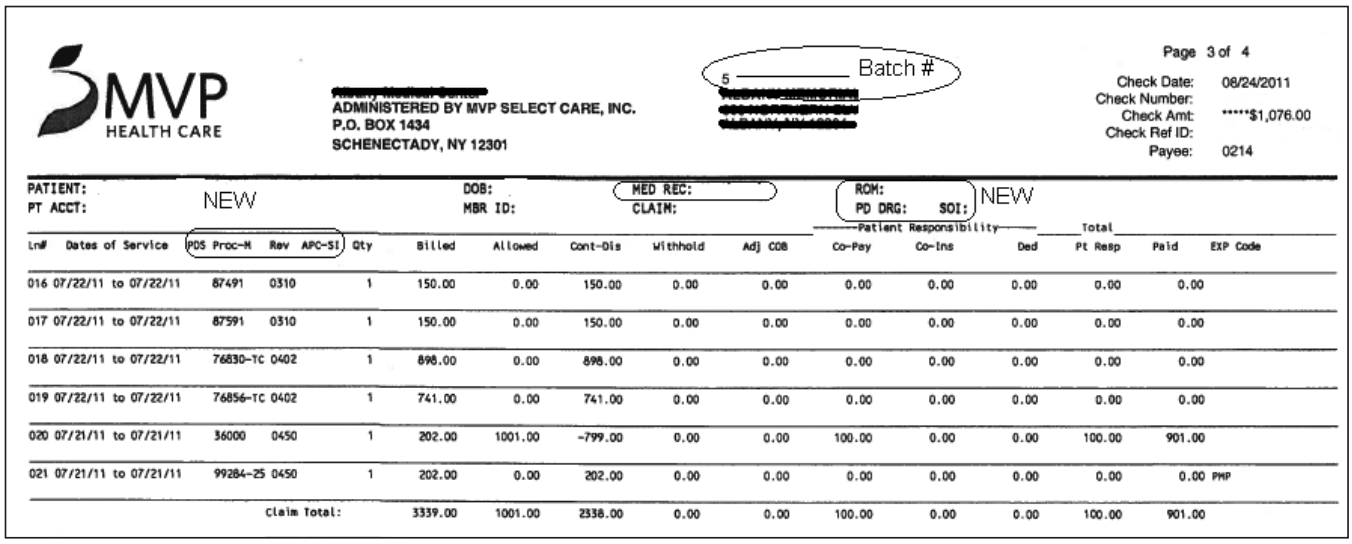
### Facets Explanation of Payment (EOP)/ Remittance Enhancements

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 |



MVP HEALTH CARE

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

5 [redacted] Batch #

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

PATIENT:
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 | PMP |
| | | | Claim Total: | | | | 3339.00 | 1001.00 | 2338.00 | 0.00 | 0.00 | 100.00 | 0.00 | 0.00 | 100.00 | 901.00 | |

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 above. *(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.

# Quality Updates

## 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.**

# 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 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**

This policy addresses ChemoFX®, Fluorescent Cytoprint Assay and Human Tumor Stem Cell Drug Sensitivity 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.

**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).

## New diabetes prevention program launches January 1

MVP Health Care is partnering with the Diabetes Prevention and Control Alliance to offer the DPCA's diabetes prevention program to members of MVP's Medicare Advantage Plans beginning January 1, 2012. The Diabetes Prevention Program (DPP) is an evidence based intervention program designed for individuals with prediabetes (an A1c between 5.7 and 6.4 or a fasting blood glucose of 100-125) that goes well beyond traditional weight loss. It is a proven, prescriptive 16 session lifestyle intervention that addresses diet, activity and behavior modification. It is administered through neighborhood health and wellness organizations, such as the Y USA. All 2012 MVP Medicare Advantage Plans will include the DPP as a covered preventive health benefit with no copay, coinsurance or deductible. Look for more details in the January issue of *Healthy Practices*.

# 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.