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IN THIS ISSUE

Caring for Your Older Adult Patients

Managing osteoporosis in the elderly

Osteoporosis is a disabling condition that affects 55 percent of the American population aged 50 and older. This condition is primarily asymptomatic and often not diagnosed until after an initial fracture. According to the National Osteoporosis Foundation (NOF), one in two women age 50 or older will suffer an osteoporosis-related fracture in their lifetime.

MVP Health Care has adopted the NOF guidelines, *Prevention and Treatment of Osteoporosis*. Key recommendations include:

- Bone Mineral Density (BMD) testing for women aged 65 and older. For post-menopausal women, testing should begin between 50 and 69 if they have risk factors for the condition. BMD testing should be performed after a fracture to determine severity of the disease.
- Anyone with hip or vertebral fractures should be considered for treatment, as well as those with low bone mass according to their Dual-Energy X-ray Absorptiometry (DXA) score. FDA-approved treatments include biphosphonates, estrogens, miscellaneous hormones (e.g. calcitonin) and estrogen/progesterone combinations.
- Calcium (> 1,200 mg) and vitamin D (800 – 1,000 IU) should be taken daily by adults aged 50 and older, regardless of whether other medications to prevent or treat osteoporosis are prescribed.

Despite the availability of specialized tests to detect osteoporosis and medications to prevent it, the condition remains largely under-diagnosed and under-treated. According to MVP's 2010 HEDIS results, only 25.24 percent of women ages 67 or older received a BMD test or prescription for a medication to treat/ prevent osteoporosis within the six-months following a fracture.

The last issue of *Healthy Practices* included an article about the Centers for Medicare & Medicaid Services (CMS) expectations for the quality of care and service offered by Medicare Advantage plans and participating physicians. CMS has developed ratings to measure how MVP is working with physicians to continually achieve excellence in the quality of health care that our members receive. The CMS has set a goal that at least 85 percent of women ages 67 and older received a BMD test or prescription for a medication to treat/ prevent osteoporosis within the six-months following a fracture.

MVP offers several tools to assist practitioners in managing osteoporosis:

- Twice a year, MVP sends reports to primary care physicians on their female patients aged 67 and older who have sustained a fracture. The reports, based on information from claims, are intended to be informational in nature and serve as a reminder to discuss osteoporosis treatment.
- In addition to the guidelines, the MVP Physician Quality Improvement Manual includes a link to the World Health Organization's Fracture Assessment tool (FRAXX) and helpful sheets from the CDC guide, *Preventing Falls: How to Develop Community-based Fall Prevention Programs for Older Adults.* This guide includes information on how to build an effective program, useful tools such as a *Fall Risk Assessment, Sample Medication Review Form* and a Sample Home *Fall Prevention Safety Checklist*. To access the QI Manual, visit **www.mvphealthcare.com/provider** and click on *Quality Improvement Manual* under *Quality Programs*. The aforementioned tools can be found in the *Women's Health and Quality Improvement* in the *Clinical Setting* sections.

Check in with your patients

Whether your older adult patients visit you for a routine check-up or something more serious, taking a moment to ask about the symptoms on this checklist may help identify problems that many people have as they grow older. Some patients may not think to mention these symptoms to you until you ask about them!

- urinary incontinence
- balance problems, dizziness or falls
- feeling sad or isolated
- trouble with vision or hearing
- memory deficits
- pain from arthritis or when performing everyday activities

MVP HEALTH CARE

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Health Care Reform Update

Could Vermont really have a single payer system?

The short answer is no. An analysis by MVP Health Care concludes that from a provider perspective, practice managers would continue to deal with multiple private insurers and with different coverage policies much as they do today. The reason for this is that not every patient a Vermont physician or provider sees will be covered by the state's proposed plan.

Exceptions would include:

- Out-of-state students attending schools and colleges in Vermont who would continue to be covered under their parents out-of-state health plans,
- Out-of-state residents visiting Vermont on vacations and for business,
- Vermont residents who work out-of-state in New York, Massachusetts or New Hampshire and have employer-sponsored insurance from plans licensed in those states.
- Patients on Medicare
- Patients injured in motor vehicle accidents whose injuries are covered by auto insurance
- Patients injured at work, who are covered by workers compensation insurance

This analysis means that providers' administrative costs will not decrease as much as the designers of the single payer plan suggest.

Other questions of concern to providers:

- How will the new plan affect provider reimbursement?
- Will the terms and conditions of such a plan affect the willingness of physicians and providers to practice in Vermont in the future?

As the state continues to develop the proposed new health plan, MVP Health Care will continue to advance these questions on behalf of our participating providers.

Professional Relations Updates

Changes to contrast materials reimbursement effective July 1

MVP Health Care has determined that the cost of *ionic contrast* is included in the fee paid for CT and other contrast enhanced exams and additional payment for this material is no longer warranted.

Reimbursement for *non-ionic* contrast was initially significantly more costly than the ionic contrast agent, and the use was to be limited to occasional patients based upon sensitivity to ionic contrast. This basis for payment no longer applies as the cost of non-ionic contrast has approached that of ionic contrast. In addition, non-ionic contrast material has become routinely used regardless of patient history. Therefore, MVP considers such use of both contrast material as part of the underlying examination and will consider them inclusive to the primary procedure fee and not separately reimbursable.

Effective July 1, 2011, providers will not be reimbursed separately for contrast material for the codes listed below. This will apply to all participating providers (physicians, hospitals and other facilities) for all MVP Commercial and Option (Medicaid) products.

HCPCS Code	Gadolinium
A9579	Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (NOS), per ml
HCPCS Code	**Non-Ionic, Low Osmolar Contrast**
Q9951	Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml
Q9965	Low osmolar contrast material, 100-199 mg/ml iodine concentration, per ml
Q9966	Low osmolar contrast material, 200-299 mg/ml iodine concentration, per ml
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml
HCPCS Code	**Ionic, High Osmolar Contrast**
Q9958	High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
Q9959	High osmolar contrast material, 150-199 mg/ml iodine concentration, per ml
Q9960	High osmolar contrast material, 200-249 mg/ml iodine concentration, per ml
Q9961	High osmolar contrast material, 250-299 mg/ml iodine concentration, per ml
Q9962	High osmolar contrast material, 300-349 mg/ml iodine concentration, per ml
Q9963	High osmolar contrast material, 350-399 mg/ml iodine concentration, per ml
Q9964	High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

This policy does not affect reimbursement paid at a global rate. MVP members are not liable for payment of contrast material fees.

Update to claim adjustment request form (CARF)

The Claim Adjustment Request Form (CARF) has been updated to accommodate more types of documentation submissions and can now be used by all MVP regions. You can begin to use the updated form immediately.

The CARF should be submitted with claims that are corrected or changed from the originally submitted claim. This applies when the original claim denied or paid incorrectly due to information on the claim. The CARF also should be used to submit documentation such as office or surgical notes for a claim that has already processed or to submit another carrier's Explanation of Payment (EOP) for Coordination of Benefits (COB) purposes.

The updated CARF is available on online at **www.mvphealthcare.com/provider/forms.**

New look, new name for the "BIM"

Effective July 1, 2011, the *MVP Health Care Benefit Interpretation Manual (BIM)* will have a new look and will simply be called the ***MVP Health Care Medical Policy Manual.***

The manual will continue to be your resource for any medical policy questions you may have. The revised look of the individual

policies includes all of the features of the BIM, along with additional information to make it a more user-friendly tool. You will see new information categories that document information that is applicable to the specific medical policy. Some of the new headings that will be included are:

- Codes Requiring Prior Authorizations
- Codes Subject to Retrospective Review
- Experimental/Investigative
- Common Diagnosis Codes
- Common Procedure Codes

The new *MVP Medical Policy Manual* will replace the BIM posted to the *Online Resources* section of MVP's Web portal for providers when you log in at **www.mvphealthcare.com/provider.** To see a sample policy, visit **www.mvphealthcare.com/provider/documents/sample-policy.pdf.**

Provider Resource Manual changes

MVP Health Care is in the process of integrating all of its policies for health care providers and will be housing those policies in the *Provider Resource Manual (PRM)*, an electronic file posted to MVP's Web portal for providers. In the past, the *Provider Resource Manual* was updated once a year. Since we are moving policies into the PRM and policy updates occur year-round, we are increasing the frequency of PRM updates to quarterly (1/1, 4/1, 7/1, 10/1), with the next update scheduled for 7/1.

To access the PRM, log in at **www.mvphealthcare.com/provider**, click *Online Resources* and then *Provider Resource Manual.*

Each updated PRM will be online 30 days prior to its effective date for providers to review. To make the document easier to navigate, you will find a link to each section of the PRM, so you no longer have to scroll through the entire document to get to the information you need. Along with a preview of the upcoming updated version, the currently-effective PRM also is posted.

Please be sure the check the Web site often for the updates to MVP's policies and procedures for participating health care providers.

Reminder of Clinical Editing update based on Upstate NY LCD

In August 2009, MVP upgraded clinical editing software as part of our routine claims software maintenance including implementation of diagnosis-matching edits for all lines of business in accordance with the Medicare Local Coverage Determinations (LCD) for Upstate New York. This is a reminder that this clinical editing applies to the following services:

- *Transthoracic Echocardiography* – (CPT™ Codes: 93303, 93304, 93306, 93307, 93308, 93320, 93321, 93325, 93350, 93351, and 93352. HCPCS Codes: C8921, C8922, C8923, C8924, C8929, and C8930)
- *Sleep Studies* – (CPT Codes: 95805, 95806, 95807, 95808, 95810, and 95811)
- *Facet Joint Injections and Denervation* – (CPT Codes: 64470, 64472, 64475, 64476, 64622, 64623, 64626, and 64627)

In April 2010, a *FastFax* communication was sent to the network changing the process so that the codes listed above would deny, rather than pend for review, when submitted with a diagnosis code that is not listed in the corresponding LCD. The full listing of diagnosis codes can be found in the Upstate New York LCD located on the CMS Web site.

This claims processing procedure applies to all claims; physicians, hospitals and ambulatory surgery centers.

Credentialing Updates

Practitioner registration

A reminder that the following practitioner types are not required to be credentialed but must undergo a registration process: Hospitalists* (Internal Medicine, Pediatric and Family Medicine), Emergency Department Physicians*, Pathologists, Anesthesiologists*, Neonatologists*, Intensivists*, Certified Registered Nurse Anesthetists, Nurse Practitioners and Physician's Assistants.

***Exceptions:** Anesthesiologists who want to be designated as a Pain Treatment specialist, Neonatologists and Intensivists who will provide services outside of the NICU or ICU and Hospitalists who provide outpatient services. Emergency Physicians who also provide services in an urgent care center, or any other outpatient setting, must be credentialed.

Registration forms may be found in the provider section of the MVP Health Care Web site at **www.mvphealthcare.com/provider/ny/forms.html.**

Hospital privileges/continuity of care

MVP endorses the following principle: In accord with medicine's ethical mandate to provide for continuity of care and the ethical imperative that practitioners not abandon their patients, practitioners must provide ongoing care for the entire episode of required medical treatment including the inpatient and outpatient setting.

Practitioners are required to ensure continuity of care for MVP members. They are accountable for their patient's entire episode of care, which includes the inpatient and outpatient setting. Practitioners who do not maintain hospital admitting and/or consulting privileges, are required to have an acceptable admitting/coverage arrangement at a par hospital with another MVP participating practitioner of the same specialty or a participating hospitalist group. Specific requirements vary by specialty. It is recommended that you refer to the *Provider Resource Manual* or the MVP Web site at **www.mvphealthcare.com/provider/credentialing.html** for general information on credentialing.

Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the January meeting. Some of the benefit interpretation 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 policy updates. If you have questions regarding the 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 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 June 1, 2011

Bone Density Study for Osteoporosis (Dexa)

- The following three indications were added:
  - Postmenopausal women age 65 and older and men age 70 and older
  - Postmenopausal women and men age 50-69 with strong risk factors for osteoporosis, to screen for reduced bone mass, with willingness and intent to treat
  - Patients who have had a fracture, to diagnose osteoporosis and assess its severity in the context of clinical management
- Vertebral fracture with dual x-ray absorpitometry (DXA) is considered to represent vertebral fracture assessment only. It does not represent a bone density study and, therefore, should not be used for screening.
- Vertebral fracture with dual x-ray absorpitometry (DXA) is not considered medically necessary for vertebral fracture assessment as there is alternative diagnostic imaging available.

Brachytherapy for Breast Cancer

- Brachytherapy for breast cancer is indicated as an adjunct to whole-breast radiation therapy after breast-conserving surgery in patients with unilateral stage I or II breast cancer.
- There have been no changes to this policy.

Chemical Dependency

There have been no changes to this policy.

Eating Disorders

There have been no changes to this policy.

Epidermal Nerve Fiber Density Testing – NEW Policy

- Epidermal nerve fiber density testing requires all the following to be met:
  - the patient presents with painful sensory neuropathy; and
  - physical examination shows no evidence of findings consistent with large fiber neuropathy, such as reduced or absent muscle-stretch reflexes or reduced proprioception and vibration sensation; and
  - electromyography and nerve-conduction studies are normal and show no evidence of large fiber neuropathy.
- Epidermal nerve fiber density testing must be requested and performed by a neurologist or a physiatrist.

Injection Procedures for the Management of Chronic Spinal Pain

- Diagnostic and therapeutic epidural and intrathecal injections criteria follow Medicare criteria.
- Therapeutic intrathecal (subarachnoid) injections and infusions are indicated for cervical, thoracic, and lumbar pain.

Methadone Maintenance

- Language was added that the methadone must be supplied by the outpatient Methadone Treatment Program and is global to the contracted rate.

Neuropsychological Testing

- Language regarding computerized neuropsychological testing was added. Computerized neuropsychological testing is limited in its ability to offer a comprehensive battery of tests and is considered not medically necessary.
- The following language was added to the New Hampshire variations section:
  - although medically necessary diagnosis and treatment of pervasive developmental disorder or autism is covered, neuropsychological testing is considered not medically necessary.
  - neuropsychological testing is not included in the American Academy of Pediatrics Guidelines for the identification, evaluation, and management of children with autism spectrum disorders.

Psychological Testing

There have been no changes to this policy.

Radiofrequency Ablation for Spinal Pain/Rhizotomy

- The policy follows Medicare criteria.
- Both Medicare and Commercial plans allow coverage for severe cancer pain.
- Coverage is allowed for cervical, thoracic, and lumbar rhizotomy when criteria are met.
- Services must be performed by a Pain Management Specialist, Radiologist, Orthopedist, Anesthesiologist, Physiatrist, or Neurosurgeon.

Ventricular Assist Device (Left)

- The policy follows Medicare criteria.
- The policy was updated to include criteria changes to ventricular assist devices for destination therapy.

The policies listed below were presented to the QIC at the April meeting. The policies were recommended for approval without changes. QIC approved the recommendation.

- Acute Inpatient Rehabilitation
- Allergy Testing & Allergen Immunotherapy
- Ambulatory Holter Monitor/30-day Cardiac Event Recorder/Monitor
- Cardiac Output Monitor/Thoracic Electrical Bioimpedence
- Cardiac Procedures
- Cardiac Rehabilitation Phase II
- CT Brain
- CT Chest
- CT Extremity
- CT Neck
- CT Pelvis
- Experimental or Investigational Procedures
- Home Uterine Activity Monitoring
- Magnetoencephalography
- MR Spectroscopy
- Needle-free Insulin Injector
- Nesiritide Infusion for Heart Failure – Outpatient
- Nuclear Stress Testing
- Panniculectomy/Abdominoplasty
- Phototherapy, Photochemotherapy, Excimer Laser Therapy
- Pulmonary Rehabilitation (Respiratory PT)
- Spinal Cord Stimulator for Intractable Pain

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.

EDI Updates

5010 testing update

- MVP is live on 5010 for Eligibility (270/271) and Claim Status (276/277). These transactions are facilitated by Post-n-Track®. Please contact them for testing (**860-257-2030** or **www.post-n-track.com**).
- Currently testing Claims (837I/837P) and returning 999 (Acknowledgement) and 277CA (Claims Acknowledgement).
- Once a Trading Partner has successfully completed testing 5010 claims, they may move to Production for 5010 Claims
- Electronic Remittance Advice (835) testing available as of June.
- Complete cycle testing will be available as of July 1.

If you have any questions about testing, please contact MVP's EDI Services team via e-mail at **EDIServices@mvphealthcare.com**.

EDI tips

- When doing a Claim Status Inquiry (276), remember to use the Rendering Provider and their 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.
- MVP accepts both "A" members and "8" members for Real-Time Eligibility via Post-n-Track. Sign up today!

Common 5010 claim errors to avoid

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

5010 835 changes & improvements

- The Front Matter of the 835 TR3 has been improved.
- Front Matter explains in detail the use of the PLB segment.
- Detailed explanation of the proper method to do Reversals and Corrections (the "CR" correction code has been eliminated).
- Payers are not to reissue 835's for lost and reissued checks.
- New Date segment added for term date when part of a claim was denied because of member coverage being terminated.
- Data structure of the 835 remains basically the same in 5010 as was in 4010.
- Improved guidance on balancing the 835.
- The 5010 835 handles input from both 5010 and 4010 claims.

Pharmacy Updates

Updates effective May 1, 2011

Allegra/Allegra-D now available OTC

- In January 2011, the FDA approved Allegra and Allegra-D for sale over-the-counter. Product became available in stores in March. Effective 5/1, MVP will no longer cover Allegra, Allegra-D and all generic equivalents under the prescription drug benefit.

Pantoprazole: removal of prior authorization

- Effective 5/1, pantoprazole (generic Protonix) will no longer require prior authorization if prescribed once daily. Prior authorization will continue to be required if prescribed more than once daily and for brand Protonix. The preferred proton pump inhibitors are omeprazole, lansoprazole, pantoprazole and Nexium.

Arthritis, Inflammatory Biologic Drug Therapy

- Coverage for Wegener's indication will be reviewed on a case-by-case basis.
- Failure on NSAIDs is not required for psoriatic arthritis.
- Psoriatic arthritis spinal disease will follow AS criteria.
- Medicare variation language was updated.

Pain Medication

- Embeda, Exalgo and Onsolis were added to the policy and require step therapy and/or prior authorization per existing policy criteria .

Pharmacy Programs Administration

- The drug utilization review section was updated.

Qutenza

- New policy with prior authorization criteria to include a diagnosis of post-herpetic neuralgia persistent for six months after rash/blisters have healed and contraindication or failure on standard treatment, including gabapentin, pregabalin, tricyclics, Lidoderm and capsaicin.

Weight Loss Agents

- Meridia was removed from the policy.

Updates effective June 1, 2011

Enteral Therapy New Hampshire

- Prior authorization criteria was updated and additional exclusions were added. Vendors providing enteral formulas will be required to bill through the pharmacy benefits manager system.

Enteral Therapy New York

- Exclusion language regarding anorexia and mood disorders was removed.

Enteral Therapy Vermont

- Prior authorization criteria was updated and additional exclusions were added. Vendors providing enteral formulas will be required to bill through the pharmacy benefits manager system.

Migraine Agents

- Alsuma, Sumavel and Cambia were added to the policy with quantity limits. Cambia quantity limit is 9 packets every 60 days.

Psoriasis Drug Therapy

- Stelara was added to the policy subject to the same prior authorization criteria as Remicade and Amevive.

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

- Cox-2 Inhibitors
- Physician Prescriptions Eligibility
- Prescribers Treating Self or Family Members
- Sabril
- Select Hypnotics

Updates effective July 1, 2011

Cosmetic Agents

- Language added to required prior authorization for topical tretinoin products for members age 31 and older.

Drugs requiring prior authorization

The following medications will require prior authorization for Commercial members, effective 7/1:

Drug Name	Policy criteria to include (but not be limited to)
Lovaza	Triglycerides U 500mg/dL AND failure of a 3-month trial on fish oil AND gemfibrozil, fenofibrate OR a formulary nicotinic acid derivative
Oracea & Doryx	Failure or intolerance to at least one generic doxycycline product
Solodyn	Failure on a 3-month trial of select topical acne treatments AND doxycycline or tetracycline AND minocycline
Benzaclin, Ziana, Duac, Epiduo, Retin-A	Diagnosis of acne vulgaris and failure on a 3-month trial of two of the following: 1) topical generic retinoids, 2) topical generic erythromycin or clindamycin 3) generic benzoyl peroxide
Topical retinoids in members 31 years of age and older	Diagnosis of acne vulgaris
Xyrem	Diagnosis per FDA approved indications
Xifaxan 200mg	Diagnosis of travelers diarrhea

Specialty program expansion

Effective 7/1, MVP will require members in products other than HMO to obtain specialty drugs from our preferred specialty vendor, CuraScript. This program will also be expanded to include members in Vermont and New Hampshire. MVP will send you written notification and a list of your members who will be impacted by any of the above changes.

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
Halaven *(medical benefit)*	Breast cancer
Egrifta	Lipodystrophy in HIV patients
Teflaro *(medical benefit)*	IV cephalosporin
Latuda	Schizophrenia
Pradaxa	Anticoagulant
Kombiglyze XR *(diabetic benefit)*	Type 2 diabetes
Nuedexta	Pseudobulbar effect
Lo Loestrin-FE	Oral contraceptive
Bromday	Ocular inflammation
Gamunex-C *(medical benefit)*	Primary immunodeficiency
Atelvia	Postmenopausal osteoporosis
Kapvay	ADHD
Xgeva	Prevention of SREs
Natroba	Head lice infestations
Abstral	Breakthrough pain in cancer patients
Amturnide	High blood pressure
Sayfral	Contraception
Moxeza	Bacterial conjunctivitis
Ofirmev	Pain and fever reduction

Generic drugs added to Formulary (Tier 1)

amlodipine/benazepril
doxycycline (generic Doryx)
mefenamic acid
propafenone ext-rel

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

ActoPlus Met XR	Natazia
Cycloset	Oleptro
Embeda[ST,QL]	Suboxone Film
Exalgo[ST, QL]	Zortress
Mirapex ER	Zymaxid

Drugs removed from the Formulary* *(change from Tier 2 to Tier 3):*

Aricept/Aricept ODT (effective 7/1/2011)

*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

Formulary updates for Medicare Part D members

Medicare Part D Formulary available from ePocrates®

You can now access and download the MVP Medicare Part D Formulary for 2011 from ePocrates®. Simply follow the instructions on our Web site at **www.mvphealthcare.com/provider/pharmacy.html**.

The tier and prior authorization status of the following medications have been approved. Policies, where applicable, can be found on our Web site at **www.mvphealthcare.com/medicare/2011MedicarePARTDPAlist.html.** A complete list of formulary changes may be found at **www.mvphealthcare.com/medicare/documents/Formulary.pdf.**

The following drugs will be removed from the Medicare Part D Formulary effective June 1, 2011:

Drug Name	Reason for Change	Alternative Drug	Alternative Drug Tier
Accolate 10mg, 20mg	Generic alternative available	zafirlukast	Tier 1
Ambien CR 6.25mg	Generic alternative available	zolpidem[QL] ER 6.25mg	Tier 1
Amerge 1mg, 2.5mg	Generic alternative available	naratriptan[QL]	Tier 1
Arimidex 1mg	Generic alternative available	anastrozole	Tier 1
Azactam injectable	Generic alternative available	aztreonam	Tier 1
Differin gel and cream	Generic alternative available	adapalene	Tier 1
Effexor XR 37.5mg 75mg, 150mg	Generic alternative available	venlafaxine	Tier 1
Exelon capsule 1.5mg, 3 mg, 4.5mg, 6mg	Generic alternative available	rivastigmine	Tier 1
Keppra injectable 100mg/ml	Generic alternative available	levetiracetam	Tier 1
Lovenox, 60mg, 80mg, 100mg, 120mg 150mg	Generic alternative available	enoxaparin	Tier 3
Merrem	Generic alternative available	meropenem	Tier 1
Mirapex 0.75mg tablet	Generic alternative available	pramipexole	Tier 3
Prevacid disintergrating tablet 15mg, 30mg	Generic alternative available	lansoprazole[QL]	Tier 1
Yaz	Generic alternative available	drospirenone/ ethinyl estradiol	Tier 1
Zegerid capsules	Generic alternative available	omeprazole[QL]/ sodium bicarbonate capsule	Tier 1

The following drugs were removed from the Medicare Part D Formulary effective July 1, 2011:

Name of Drug	Reason for Change	Alternative Drug	Alternative Drug Tier
Lovenox 30mg, 40mg	Generic alternative available	enoxaparin[QL]	Tier 3
Myfortic 180mg, 360mg	Requires B vs. D coverage	determination	

Beginning **April 15, 2011**, the following drugs will require prior authorization (at the pharmacy) for End Stage Renal Disease patients currently receiving dialysis to determine if drug should be obtained by the dialysis center and billed with dialysis services:

Aranesp*	levocarnitine
Boniva Inj*	Miacalcin
Boniva Tabs	pamidronate*
Calcitriol	Procrit*
Cubicin	vancomycin
Epogen*	Zemplar caps
Hectoral	Zemplar Inj*

*Currently require prior authorization at all locations. As of 4/15/2011, these drugs will also be reviewed to determine if the cost should be billed along with dialysis service.

Medication recalls and withdrawals

The Food and Drug Administration (FDA) has recently issued important medication warnings, withdrawals and recalls. Highlights of the FDA activity include:

- On January 6, 2011, Teva Pharmaceuticals voluntarily recalled Metronidazole Tablets USP, 250mg, lot 312566, expiration date 05/2012. This product lot was called due to the presence of underweight tablets.

UM Update

2011 Ambulatory Surgery Procedure and In-Office Procedure lists effective August 1, 2011

The *2011 Ambulatory Surgery Procedure and In-Office Procedure* lists were approved by the Quality Improvement Committee (QIC) in April and will be effective August 1, 2011.

Coverage for the ambulatory procedures is limited to the ambulatory surgery, out-patient hospital, or in-office settings. Claims submitted with a place of service other than these settings will be denied unless prior authorization is obtained. Use of appropriate place of service setting does not override any existing prior authorization requirements.

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 Ambulatory Surgery Procedure and In-Office Procedure* lists are located on the MVP Web site at **www.mvphealthcare.com/provider/ny/reference.html.**

Quality Improvement Updates

Physician notice: Health Care Price and Quality Transparency Rule

Pursuant to Act 191 and the resulting Health Care Price and Quality Transparency Rule, physicians can review the physician quality information currently displayed on MVP's Web site. MVP provides physician quality information based on NCQA's physician recognition programs.

If you have received recognition in one or more of the NCQA programs, the appropriate NCQA seal(s) is displayed next to your listing. You may access the information by looking up your listing using the *Provider Search* feature of the MVP Web site at **www.mvphealthcare.com**. If a recognition seal is missing from your name or a seal is displayed incorrectly, call MVP's Quality Improvement Department at **1-800-777-4793, ext. 2023**.

Act 191 also requires MVP to provide price information to members for certain provider and hospital services. BISHCA identified the specific CPT codes, DRGs, and ICD-9 procedure codes that MVP must price. You can view a list of the CPT codes on MVP's Web site. Go to **www.mvphealthcare.com/provider**,

select the *Reference* tab and then click *Vermont Health Care Price and Quality CPT Codes.* To review the list of hospital services and procedures, go to **www.mvphealthcare.com/member.** Under *Learn More,* click the *Hospital Safety* link. At the bottom of the page, find *The Hospital Report Cards* link. Then click the link under *Pricing and Financial Reports* to view the information shown in tables 1A, 2A, and 3A - 3I.

The actual price information is secure and can be viewed only by members using a unique login and password. If you would like to review the price information on display about your practice, contact the Professional Relations Department at **1-800-380-3530, opt. 4**.

Continuity and coordination of care: reports and tips available online

MVP Health Care considers communication and coordination among health care providers essential to reducing medical errors and integrating quality, safety and continuity of care.

MVP reviews primary care physician office charts annually for evidence of communication received from hospitals. Charts are reviewed for reports from hospital emergency room visits and hospital admissions. These results are accessible online at **www.mvphealthcare.com/provider**. Click the *Quality* tab in the green toolbar toward the top of the page and then *Continuity of Care Results*. These results will be available for members to review on the Web site after the 60-day review period for affected hospitals has closed.

Tips to help improve continuity and coordination of care

Primary Care Physicians

- Follow up with referrals for reports/hospitalizations.
- Review, date and initial reports in patient's record prior to filing.
- File reports in a timely manner.

Specialists

- Referral reports should be sent in a timely manner.
- Send a copy of consult reports/hospitalizations to the patient's PCP.
- Ensure that the PCP is notified of any changes in the member's medical condition.

Providers offering single visit appointments for colonoscopies

Preventive screening for colorectal cancer is an important test for adults over the age of 50. Healthy, asymptomatic individuals are quick to come up with a number of reasons to postpone or cancel a colonoscopy when their physician recommends it. One reason noted by people is the inconvenience of taking time off for the test and/or the required consultation. For some people, the lack of time presents a barrier that makes canceling the appointment seem like the right choice.

Conducting the exam during the initial visit to the specialist may be an appropriate choice when the test is conducted as a routine screening exam in an individual in good health with no chronic conditions or daily medications. For individuals diagnosed with a chronic condition or those who take daily medications, a pre-procedure consultation with the practitioner conducting the test may be indicated.

Recently, MVP surveyed GI practitioners across our service area to find those who offer single visit appointments with appropriate clearance from the patient's primary care practitioner. Listed below are the providers that offer these services within your region. Consider referring your patients to them when it is appropriate or when a patient cites time constraints as a barrier to the exam.

Additional practices that perform routine colonoscopies should also contact MVP at **1-800-777-4793, ext. 2602** so that their information can be included in future editions of this list.

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John DeFrancisco, M.D.
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Carla Fernando-Gilday, M.D.
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Alan Samuels, M.D.
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